

The Modern Hospital

APRIL 1950

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The Modern Hospital

APRIL 1950

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Published monthly and copyrighted, 1950. The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11, Ill. U. S. A. (Cable Address: Modital, Chicago.) Otho F. Ball, president; Raymond P. Sloan, vice president; Everett W. Jones, vice president; Stanley R. Clague, secretary; James G. Jarrett, treasurer. Subscription price: to hospitals and allied fields, architects, medical schools, libraries in North and South America, \$3 a year; overseas, \$5 a year. Single copies, 35 cents; back copies, 50 cents to \$1. Subscriptions from all others, \$8 a year; single copies, \$1. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U. S. A. Eastern Office, 101 Park Avenue, New York 17, N. Y. Pacific Coast Representatives, McDonald-Thompson, Los Angeles, San Francisco, Seattle, Fort Worth, Portland, Denver.

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AMONG THE AUTHORS

Dr. W. W. Stadel, whose study of worker motivation appears on page 55, is administrator of the San Diego County General Hospital, San Diego, Calif. A graduate of the University of Kansas School of Medicine, Dr. Stadel became interested in hospital administration while serving his internship and residency at the Latter Day Saints Hospital at Salt Lake City, Utah. Convinced that a firsthand knowledge of the practice of medicine would be helpful in hospital administration, Dr. Stadel spent 18 months before seeking training in hospital administration under the tutelage of the late Dr. Ben W. Black.



Dr. W. W. Stadel

Ruth Dierker Schwarzwald is director of the University of Houston nurse assistant school (see page 74). After graduation from nursing school in St. Louis, Mrs. Schwarzwald did staff nursing in St. Louis and Milwaukee. In 1941 she joined the army nurse corps and spent the next five years in such interesting and at times dangerous localities as Morocco, Naples, Cassino, Anzio, Pisa and Florence with various field and evacuation hospitals. After the war she obtained her B.S. degree and Public Health Nurse certificate from the University of California at Los Angeles.



Ruth Schwarzwald obtained her B.S. degree and Public Health Nurse certificate from the University of California at Los Angeles.

Dr. Milton I. Roemer is assistant professor of public health at Yale University, whose school of architecture conducted the seminar in hospital problems described in his article on page 76. Dr. Roemer was graduated from Cornell University in 1936 and received his M.D. degree from New York University in 1940. He also holds master's degrees in sociology from Cornell and in public health from the University of Michigan. After serving with the New Jersey State Department of Health for a year, Dr. Roemer joined the staff of the United States Public Health Service in 1943.



Dr. M. I. Roemer

Stanley P. Farwell is treasurer of Chicago's Provident Hospital, the Negro institution whose fund-raising and building programs were reported in the news columns of *The Modern Hospital* last month. A graduate of the University of Illinois with master's and doctor's degrees in electrical engineering, Mr. Farwell has been a consulting management engineer for 30 years and is president of the Business Research Corporation of Chicago. He has been a trustee and financial adviser to a number of welfare and charitable agencies in the Chicago area.



Stanley P. Farwell

David Wachs is superintendent of Beth Israel Hospital, Passaic, N.J., where the inclusive rate plan described in his article on page 68 is in effect. A graduate of City College, New York, Mr. Wachs was on the business staff of the city department of hospitals for several years before he became office manager of Jewish Memorial Hospital in New York City. He was also assistant superintendent of the Bronx Hospital before his appointment to Beth Israel five years ago.



David Wachs

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Reader Opinion

Nursing Schools

Sirs:

There has recently been brought to our attention evidence of serious misunderstanding of the activities of the National Committee for the Improvement of Nursing Services and the program of the national nursing organiza-

tions. We are taking this opportunity of explaining these matters to your readers.

The first misunderstanding relates to the status and content of the report entitled "Nursing for the Future" by Dr. Esther Lucile Brown of the Russell Sage Foundation. This report was made

at the request of the National Nursing Council with funds granted by the Carnegie Foundation. The report represents only Dr. Brown's individual views with respect to possible long-range trends in nursing education, and has not been adopted by any national nursing organization as a basis for any immediate action. Furthermore, Dr. Brown does not recommend the elimination of the present three-year hospital course of training. Dr. Brown recognizes, of course, that advanced training is needed for the nurses who are to fill the 50,000 positions in this country as administrators, teachers, supervisors and head nurses; and that, on the other hand, there is considerable room to make increased use of properly prepared practical nurses. With respect to the present three-year program, however, her only conclusion is that further study is needed to determine what nurses are actually doing in practice and what type of education is necessary to prepare them for such duties. Indeed, Dr. Brown states unequivocally (page 109 of her report): "If all hospital schools were to terminate their existence this year, however, the consequences would be disastrous."

The nursing profession is, of course, studying Dr. Brown's report with a great deal of interest and earnestness, as it has studied all reports of a similar nature prepared by competent authorities, such as the well known report entitled "Nursing and Nursing Education in the United States" by Josephine Goldmark, published in 1923; the report entitled "A Program for the Nursing Profession" by Dr. Eli Ginzberg, published in 1948, and a similar report by Dr. Thomas Murdock, published in a recent issue of the *Journal of the American Medical Association*. However, such study does not imply immediate acceptance of all recommendations contained in the report. The discussion and recommendations of Dr. Brown should not be confused with the program and policies of the national nursing organizations.

The second respect in which there appears to be some confusion is the inference that accreditation and classification activities of the national nursing organizations are in some way improper. We should like to point out that such activities are a common characteristic of all professions. For example, the American Medical Association accredits schools of medicine; and we are advised that the American Bar Association similarly accredits law schools. We fail to



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see why nurses' professional organizations should not engage in the same accrediting activities as do the national organizations of the other professions. Indeed, whereas the American Medical Association and American Bar Association carry on their accreditation activities unilaterally, the accreditation and classification activities of the nursing profession have been carried on jointly by all of the major national nursing organizations, including the National League of Nursing Education (which functions as the Department of Education of the American Nurses' Association), the National Organization for Public Health Nursing, the Association of Collegiate Schools of Nursing, and the Conference of Catholic Schools of Nursing. We might add that the fact that 96 per cent of the schools of nursing in the United States voluntarily cooperated in the recent Interim Classification would tend to show that the schools themselves recognize the need for more information with respect to the quality of their instruction as a prerequisite to the improvement of their courses of instruction.

The third matter on which we would

like to comment is that of federal aid to the health professions. S. 1453, which was passed by the Senate on Sept. 23, 1949, is a bill to provide an emergency five-year program of grants and scholarships for education in the fields of medicine, osteopathy, dentistry, dental hygiene, public health and the nursing professions. The bill as passed was the outgrowth of hearings at which testimony was introduced by the American Nurses' Association, as well as by the American Medical Association, the Association of American Medical Colleges and the American Hospital Association. At the hearings, it appeared that there was general agreement among all groups (1) that financial aid was needed by the professional schools in the health field, and (2) that, if federal aid was extended to such schools, appropriate safeguards should be incorporated in the legislation to prevent federal interference with the curriculum or administration of any school. As a result of the hearings, a number of the recommendations of the various professional organizations were incorporated in the legislation before passage by the Senate. In particular, we wish to call attention to the fact that Section 382(a) of the proposed new law would provide as follows:

"... nothing contained in this part shall be construed as authorizing any department, agency, officer or employee of the United States to exercise any control over, or prescribe any requirements with respect to, the curriculum or administration of any school, or the admission of applicants thereto."

Probably the best proof that federal aid to education is not synonymous with control comes from the field of general education. Federal support of such education and for teacher training has been provided for years with no resulting domination by the government.

The fourth subject of widespread discussion is that of proposed "socialization of the nursing, dental and medical professions." We presume that this is a reference to the controversial matter of compulsory health insurance, with regard to which the national nursing organizations have not taken any official stand. We are, therefore, not authorized to make any comment on this subject. We wish, however, to point out that S. 1453 was removed from the more controversial provisions of earlier proposed omnibus legislation and is confined to the single subject of temporary (five-year) financial aid to education in the health fields, which was consid-

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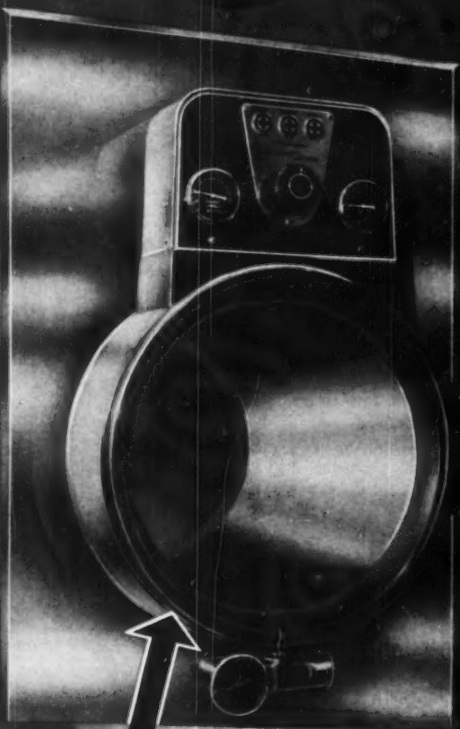
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ered a relatively noncontroversial matter. Certainly neither our committee nor the national nursing organizations have ever participated in any "preconceived design" to obtain federal control over the nursing and medical field.

Marion W. Sheahan
Director of Programs

National Committee for the
Improvement of Nursing Services
New York City

Euthanasia

Sirs:

I believe that Dr. Sander should be punished to the full extent of the law for the termination of the life of the New Hampshire housewife who was reputedly dying of cancer.

Without doubt doctors have used measures time and time again to relieve suffering in such cases and hasten death. In isolated cases this may be justifiable. It would seem to be the only human thing to do under certain circumstances.

But such action always presupposes that the patient will die soon anyway. This fact is left to the judgment of one man. It is also presupposed that he is capable through training and experience to judge the conditions. Probably he is capable.

The decision which is rendered in Dr. Sander's case will not decide only whether or not he was guilty of murder in that one case. This is obviously a test case. If he is acquitted it will mean that hereafter any doctor can, if he thinks best, terminate the life of a patient.

Who will define when a patient is incurable? Who will decide whether the patient will live hours or weeks more? Any licensed physician will have the right.

Since the turn of the century, and especially since 1914 when the American College of Surgeons started its work of hospital standardization, hospitals and medical staffs have been trying to arrive at a point where doctors would do only that work of which they were capable. All of us know that in many hospitals there are still problems along this line. Can we now assume that doctors will be entirely ethical in the matter of terminating life? Will there not have to be hospital rules to protect the patient?

To get a good idea of the problem, try drawing up the rules to be followed in your hospital when a doctor wants to terminate the life of a patient. Consultations will be necessary, of course, and forms will be necessary providing

for the signature of the next of kin in case he decides to sue you later.

I repeat, I think Dr. Sander should be punished to the full extent of the law. We should not let such a procedure become common practice with the approval of society and the law.

Kenneth L. Winters
Administrator

Olean General Hospital
Olean, N.Y.

Sirs:

I noted an arresting article in your January issue, page 100, and wondered if the article is truly factual—and do not believe that it is—and wonder if individual and group political or ideological grievances (outside the scope of relevant material or that may serve to create ill-will or to reopen old sores) fit into technical-professional journals.

Do you recall Stalin's statement during Russia's recent war with Germany that "There are 20 million Germans too many"?

As for euthanasia, why not give the wretched, hopeless individuals who are committed to asylums for the insane a choice—to continue the immured existence or to have surcease and be happy in Heaven forevermore?

George Blumenauer

Little Rock, Ark.

We Can't Add

Sirs:

In your January issue in a news item, you refer to my utterances at the hospital planning conference of the New England States.

You credit me with stating that "\$12,000,000,000 in hospital construction would be needed throughout the country" presumably to meet our present hospital requirements. You further credit me with having stated that "an additional \$15,000,000,000 worth of furnishings, equipment and other capital expenses would be needed to provide an adequate number of beds to care for the population."

This is erroneous inasmuch as I stated that \$12,572,000,000 would be needed to supply our hospital needs and that 25 per cent should be added to cover the cost of furniture, furnishings, movable equipment, yard work, and professional fees. The total bill, therefore, would be \$15,700,000,000 exclusive of the cost of the land.

Isadore Rosenfield
New York City

For a dumb mathematical error, The MODERN HOSPITAL apologizes to Mr. Rosenfield and other readers.—Ed.



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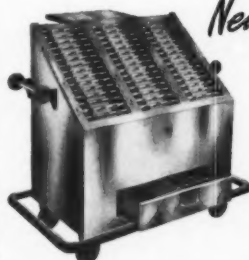


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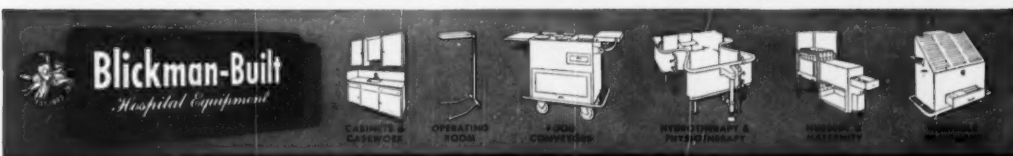
COMMANDER CHART CARRIER
No unauthorized person can remove charts. They are locked in with a 2-way key-in-handle lock. Welded, stainless steel construction throughout. Bracket-supported drop-type writing shelf. Two-compartment drawer for forms and records. Heavy-duty disc-type casters. Continuous rubber bumper. Sizes to hold 20, 30, 40, 45, or 60 charts.

Send for Bulletin 2-CDC illustrating and describing in detail many different models of chart desks, carriers and holders.



S. BLICKMAN, INC.

1504 Gregory Ave., Weehawken, New Jersey
New England Branch: 10 High Street, Boston 10, Mass.



You are welcome to our exhibit at the Middle Atlantic Hospital Assembly, Buffalo, N. Y., Booths No. 304-305, May 24-26

You asked for it

and we are proud to present the NEW

Ideal

PORTABLE HOT PACK HEATER

(MODEL 812-J)



Now you can have a beautiful, stainless steel, hot pack heater that anybody can easily carry about. Designed especially for the heating of small stupes, towels, dressings and smaller Kenny packs, this new Ideal Hot Pack Heater squarely meets an urgent request from Henry Ford Hospital and other leading institutions. It supplies in perfected form a unit long desired for general use in hospitals, physicians' offices, clinics and for out patients.

This new Ideal Unit is so completely insulated that it can be placed on the finest furniture without damage to the finish, and handled freely without harm to operator. It can be also used as a sterilizer providing ample capacity for a large assortment of instruments. Built to Ideal Standards of quality in every detail. Write for complete specifications.



Made only by the **SWARTZBAUGH MFG. COMPANY**

ESTABLISHED 1884...TOLEDO 6, OHIO

Distributed by The Colson Corporation, Elyria, Ohio; The Colson Equipment and Supply Company, Los Angeles and San Francisco. In Canada: Canadian Fairbanks-Morse Company.

SOME FACTS ABOUT THIS NEW NURSE'S AID

- 500 Watt. AC only.
- Thermostatically controlled.
- Pilot light shows when current is being used.
- Weighs 10 lbs. 12 ounces.
- Stainless Steel body.
- Water capacity 1 quart (lasts 5 hours depending on thermostat setting).
- Anodized aluminum inset.
- Fiberglas insulation.
- No moving parts.
- Fully guaranteed for one year.



Ideal
FOOD CONVEYOR SYSTEMS
Found in Foremost Hospitals



Every Feature Needed IS IN THE NEW Infantair

- 1 The spacious cabinet allows more room, a full 4 cubic feet, to adequately serve the infant. Bed adjusts to Trendelenburg position. The cabinet measures 34 inches long, 19 inches wide, 21 inches high. Safety glass windows on top and three sides.
- 2 The NEW isolation cabinet provides ample storage facilities. A shelf attached to right hand door accommodates powder, oil or other containers.
- 3 The Infantair may be readily moved on its easy rolling ball bearing casters.
- 4 A heavy duty, completely enclosed and safe heating element maintains desired temperature by automatic, thermostatic control.
- 5 Proper humidity in any proportion is attained by adjustment of the water receptacle. No wicks to become saturated with mineral deposits.
- 6 The accessory cooling chamber converts unit to an oxygen tent.
- 7 Oxygen may be introduced thru a simple connection.
- 8 The Infantair has been thoroughly tested in hospital service. And, it has been approved by Underwriters Laboratories, Inc.

Write to Department H for full Details



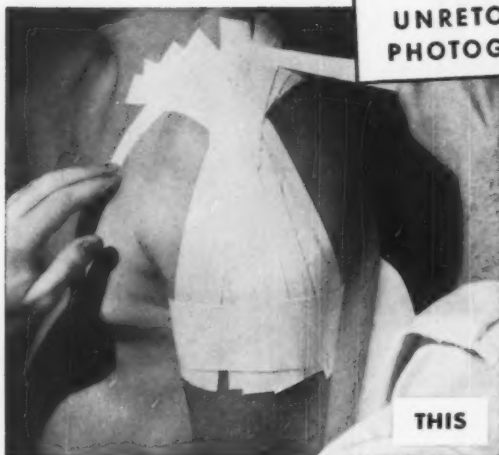
The Infantair is a development from the engineering and research laboratories that pioneered and designed the first iceless oxygen tent. With the Continentalair Oxygen Tent as an example of successful performance you can be assured of the Infantair's quality and efficiency.

CONTINENTAL HOSPITAL SERVICE, INC.

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ACTUAL,
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PHOTOGRAPHS!



THIS



NOT THIS

Curity—An Adhesive Tape REG. U.S. PAT. OFF. That Solves All These Perplexing Problems!

PROBLEM #1... WRINKLING DURING APPLICATION... Because CURITY Adhesive is made on a special cloth backing, it has more "body"... is far easier to handle. Just try a roll of CURITY Adhesive and see how *much* easier it is to tape with CURITY Adhesive, because it goes on smoothly, lies flat!

PROBLEM #2... STRETCHING—LOOSENING... The same special cloth backing of CURITY Adhesive reduces stretching and loosening... gives longer support. You actually have to retape *less frequently* with CURITY Adhesive!


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You cannot buy any adhesive which is easier to handle... gives more lasting support... is less irritating to you... and your patient!

A Product of

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 **RESEARCH TO IMPROVE TECHNIC... TO REDUCE COST**

Curity
REG. U.S. PAT. OFF.

Now! You can specify

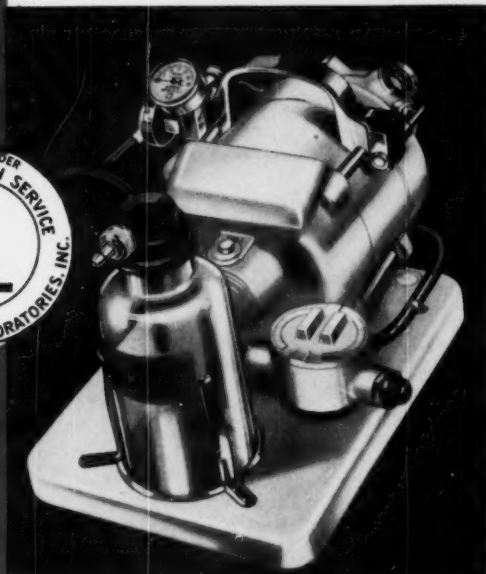
with DOUBLE ASSURANCE!

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Portable Suction and Ether Unit**



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**No. 911 L EXPLOSION-PROOF
Portable Suction Unit**

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BY UNDERWRITERS' LABORATORIES, INC.

FOR USE IN HAZARDOUS LOCATIONS, CLASS I, GROUP C

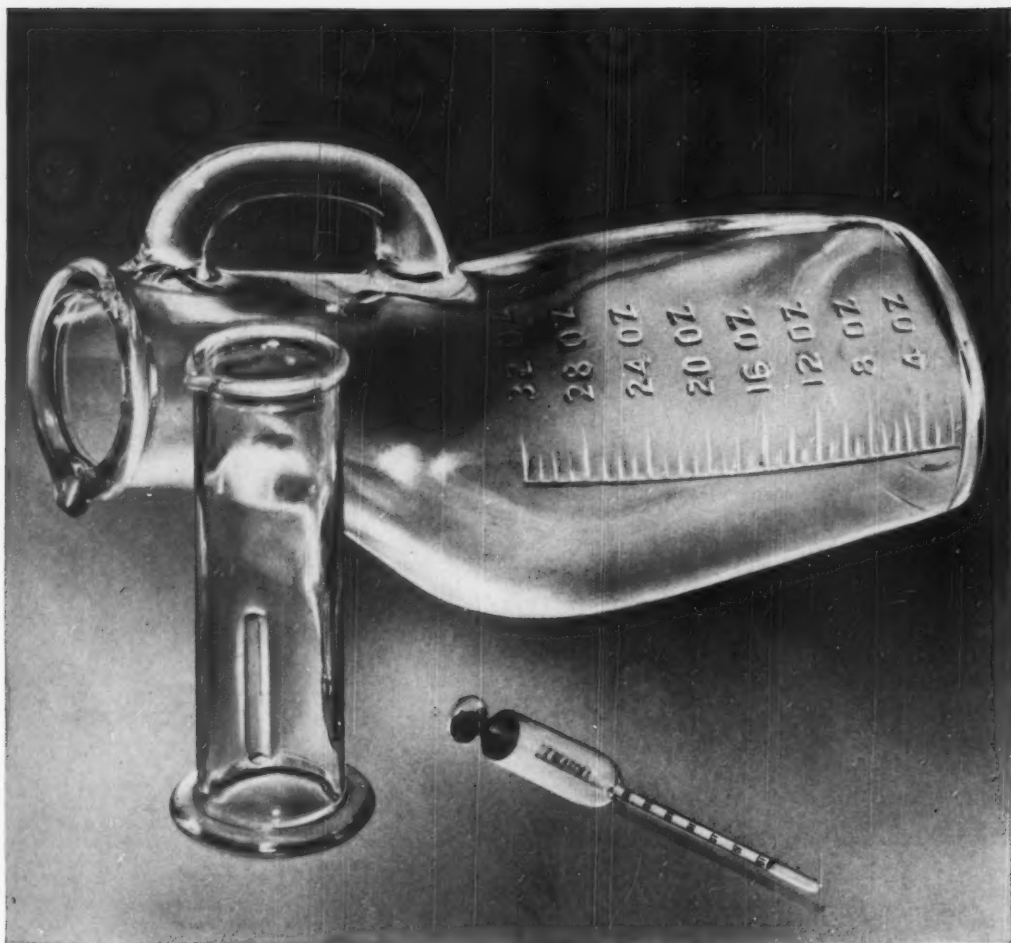
(Atmospheres containing ethyl-ether vapors)

Climaxing a ten-year reputation for safety in operating rooms, the two above units now bear the Underwriters' Laboratories seal shown. This means double assurance to the

safety-conscious hospital buyer. **BE SAFE**—**BE SURE**—ask your surgical or hospital supply dealer for these **APPROVED** portable units.

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Male urinal, specimen bottle and Urinometer typify the practical values in glassware you get from Glasco.

FOR FINE FUNCTIONAL GLASSWARE, SPECIFY GLASCO

When you specify Glasco hospital glassware, you are sure of modern functional design that facilitates use and insures accuracy. Your glassware will stand hard hospital treatment yet be moderate in cost.

The items pictured above are typical of Glasco values. The specimen bottle is carefully calibrated to 7 oz., light in weight but sturdy enough to withstand repeated handling and cleaning.

Paper caps are printed so identifying names and number can be quickly written in and easily read.

The Urinometer has fluted sides for sure holding, broad base to steady it. Large, clear figures on the mercury filled hydrometer permit accurate specific gravity readings readily.

The male urinal has graduated lines and figures pressed on the glass for easy, accurate reading when necessary.

The broad, flat bottom makes it possible to stand the urinal upright with minimum chance of being tipped over. The clear glass reveals whether the urinal is cleaned properly, removing the danger of bad odors.

For these items and for hundreds of others used in hospital operation, see your Glasco catalog, ask your hospital supply house, or write to us for details and prices.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS



FROM THE PAINTING BY SAMUEL R. MCDOWELL

COURTESY, AMERICAN COLLEGE OF SURGEONS

Irvin Abell

1876-1949

A graduate of the Louisville Medical College in 1897, Dr. Abell studied in Berlin, Germany, in 1898, and practiced surgery in Louisville from 1900 to 1949. He received Honorary Degrees from six of the leading universities of the United States, was a member and served as President of many of the leading medical and surgical organizations of the United States. He was an Honorary Fellow of the Royal College of Surgeons of England and author of more than one hundred articles published in the medical literature.

During World War I, Dr. Abell was Commander of Base Hospital No. 59 and was Advisor in Medical Affairs to the United States Government during World War II.

A Fellow of the American College of Surgeons from its founding in 1913, Dr. Abell was President—1946-1947, and Chairman of the Board of Regents—1939-1949, and President and Chairman of the Board of Directors, The Franklin H. Martin Memorial Foundation—1946-1949.

From the Series, Great American Surgeons, Published By Ethicon Suture Laboratories, Inc., New Brunswick, N. J.



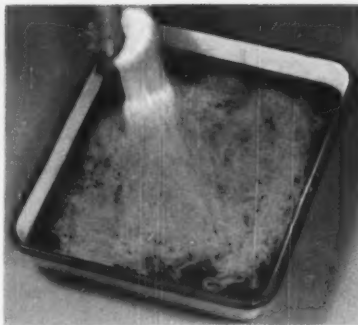
SURFACE-CHROMICIZING*

When gut is chromicized after strands are spun and dried, chrome concentration is usually high in surface layers and relatively low in the core. Core digests rapidly, but highly chromicized periphery survives for prolonged periods.

HOW SURGERY IS AIDED BY TRU-CHROMICIZING

1. Less interference with healing through minimized foreign body reaction.
2. High tensile strength of suture retained for the healing period, followed by complete absorption.
3. Uniformity in physical and physiologic characteristics essential to optimum surgical results.

*To illustrate this comparison, small laboratory trays are used. In commercial production, surface-chromicizing is done under tension. Both processes are performed in large vats.



ETHICON TRU-CHROMICIZING

Before they are spun into strands, ribbons of gut are soaked in a chrome bath, permitting uniform deposition. Thus, the strand has the same chrome content from periphery to center.

Control of Suture Digestion in Tissue

OPTIMUM RESULTS FROM ETHICON'S TRU-CHROMICIZING

- The ultimate test of the surgical gut suture is its behavior in tissue. Chromic gut is widely chosen because of its prolonged retention of useful tensile strength.

Although the chromic suture must withstand abnormal digestion conditions, the chrome content must not be so great as to prevent digestion. Heavily chromed catgut persists indefinitely in tissue and frequently causes knot extrusion.

To assure uniformity, Ethicon chromicizes gut in the ribbon stage. This exclusive, more meticulous process we call Tru-Chromicizing. An alternative method, used by others, called surface-chromicizing, involves dipping finished, spun and dried suture strands in a chrome bath. These are the usual results of the two methods:

SURFACE-CHROMICIZING

In enzyme solution, or in tissue, the core of most surface-chromicized gut digests readily, leaving a hollow cylinder which separates into ribbons.

This cylinder may be excessively resistant to tissue enzyme action and remain as an undigested foreign body for a prolonged period.

TRU-CHROMICIZING

Ethicon Tru-Chromicized gut exhibits uniform enzyme resistance throughout digestion. It digests from the surface inward, and retains its integrity as a unified suture until dissolution approaches completion.

Total digestion eliminates the danger of knot extrusions and sterile stitch abscesses.

CHROMICIZING BEFORE SPINNING

Ethicon laboratory technician checks ribbons of surgical gut preliminary to immersion in chrome bath for truly uniform chromicization. At Ethicon this process precedes spinning of ribbons into a completed suture strand.

ETHICON

Sutures

ETHICON SUTURE LABORATORIES, INC.

Suture Laboratories at New Brunswick, N. J.; Chicago, Ill.; Sao Paulo, Brazil; Sydney, Australia. In Scotland: Mersons (Sutures) Ltd., Edinburgh.



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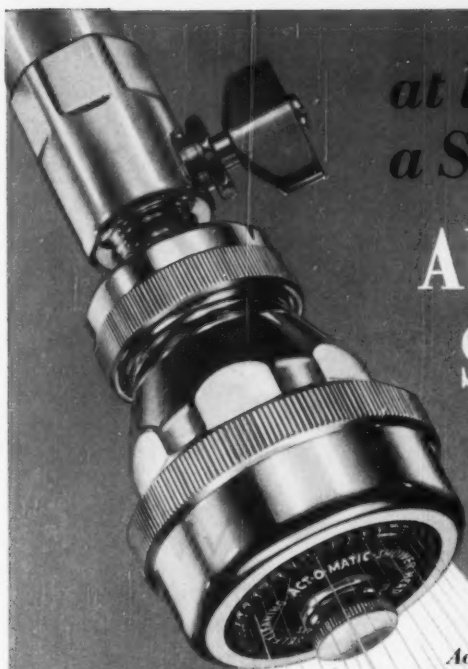
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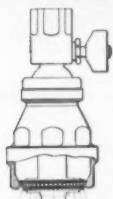
at last...
a Shower Head that's
AUTOMATICALLY
SELF-CLEANING
each time it's used

NO CLOGGING • NO DRIPPING

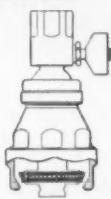
There is no shower head like the new SLOAN Act-O-Matic. The exclusive feature which sets it apart from all others is its automatic self-cleaning action. The unique spray disc moves downward into shower position when the water is turned ON. A cone-within-cone spray of maximum efficiency is delivered. When the water is turned OFF the disc is moved upward, draining the head instantly.

Because the water is completely removed, the *Act-O-Matic* SHOWER HEAD does not clog or lime up, and therefore it will not deliver irregular or distorted spray patterns. The *Act-O-Matic* is also economical in use. It saves water, fuel and maintenance service.

THE *Act-O-Matic* Disc MOVES
 EACH TIME SHOWER IS USED



DISC DOWN
 SHOWER ON



DISC UP
 SHOWER OFF

OFF position opens large, free waterway
 permitting Automatic Self-Cleaning.

SLOAN VALVE COMPANY

4318 WEST LAKE STREET

CHICAGO 24, ILLINOIS



The SLOAN *Act-O-Matic* SHOWER HEAD
 is a product of Sloan Valve Company,
 whose flush valves are in world-wide use
 —in buildings of every type
 and on ships at sea.

*More Sloan Flush Valves are sold
 than all other makes combined.*



SLOAN VALVE COMPANY

4318 West Lake St., Chicago 24, Illinois

Please send folder containing full information on your
Act-O-Matic SHOWER HEAD to:

NAME _____

FIRM NAME _____

ADDRESS _____

CITY & STATE _____



Bring the Privacy of *QUIET* TO HOSPITAL WARDS

Any hospital ward, regardless of size, can provide patients with the restful quiet and comfort they need for speedy recovery. Modern Sound Conditioning immediately muffles disturbing sounds before they can pile up into an irritating din.

Acousti-Celotex Sound Conditioning checks noise in busy hospital hallways, wards, rooms and kitchens. Voices, footsteps, bells and even dishes "quiet-down" — for good! Staff members work more efficiently, with less strain and fatigue.

Provide patients, doctors and nurses with these direct benefits of increased privacy and quiet. Acousti-Celotex Sound Conditioning has already been installed in *hundreds* of up-to-date hospitals at very moderate cost. There is a

material to suit every specification and building code requirement. Standard perforated Acousti-Celotex materials require no special maintenance, can be painted repeatedly and washed without loss of sound absorbing capacity.

FOR A FREE ANALYSIS of your particular noise problem, write now for the name of your local distributor of Acousti-Celotex products. He's an expert in modern Sound Conditioning techniques with the finest acoustical products ever developed. We will also send you a copy of an informative booklet entitled, "The Quiet Hospital." The Celotex Corporation, Chicago 3, Illinois. In Canada, Dominion Sound Equipments, Ltd., Montreal, Quebec.

THE CELOTEX CORPORATION • CHICAGO 3, ILL.



ACOUSTI-CELOTEX

Sound Conditioning Products

PRODUCTS FOR EVERY SOUND CONDITIONING PURPOSE

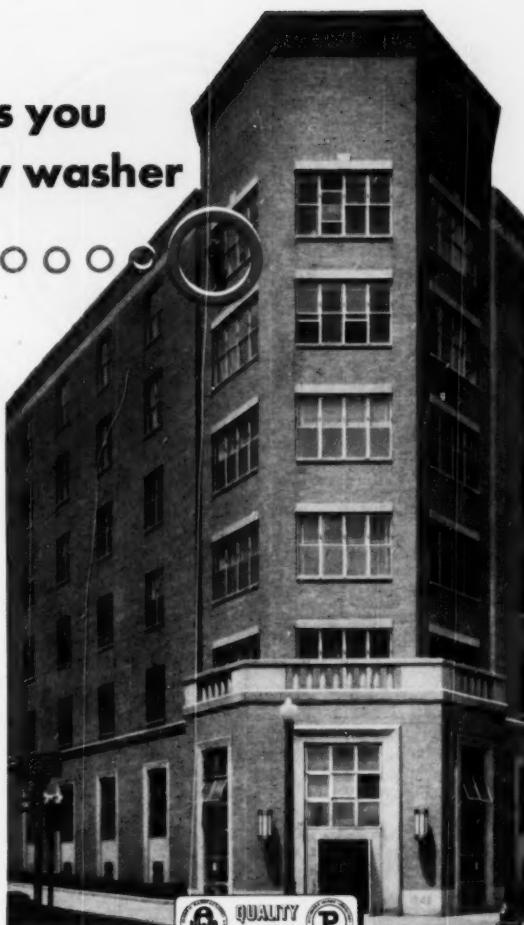
The MODERN HOSPITAL

***But Forget All
Other Maintenance!***

- Minimum Air Infiltration • Finger-tip Control
- No Warp, Rot, Rattle, Stick • No Painting or Maintenance
- Ease of Installation



Established 1857 • ELKHART, IND. • New York • Chicago



Architect: Reinhardt-Hofmeister & Walquist, N. Y. **Contractor:** Barr & Lane, Boston

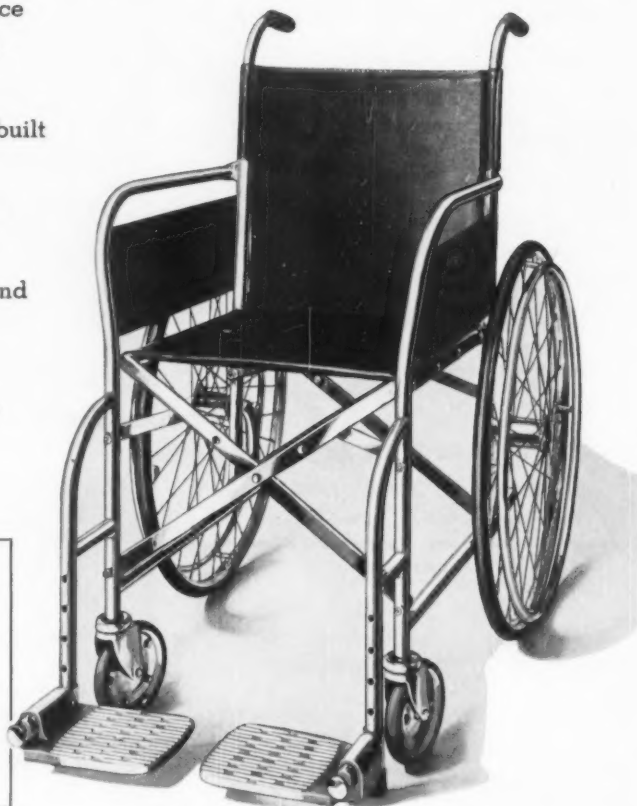
The Folding Wheel Chair

For Extra Comfort — Extra Service

● From long time experience Colson provides the utmost in wheel chair comfort and service. Every chair is built on the assumption that an invalid needs and deserves the best. A wide range of styles are available—adult and children sizes, hospital and general utility models.

Write for Wheel Chair Catalog

New model 4342 Wheel Chair—very light and strong. Folds easily and compactly—requires minimum storage space. Foot boards are adjustable—10" to 16" from seat. Thoroughly engineered and tested under load—competitively priced.



THE COLSON CORPORATION

WHEEL CHAIRS

ELYRIA, OHIO
WHEEL STRETCHERS

INSTRUMENT TABLES



ALWAYS *Steriljar*

SCANLAN SUTURES IN THE EXCLUSIVE *Steriljar*

Ohio Chemical



OHIO MEDICAL GASES — Oxygen • Nitrous Oxide • Cyclopropane • Carbon Dioxide • Ethylene • Helium and mixtures • Also Laboratory Gases and Ethyl Chloride.

A POTENTIAL REVENUE PRODUCER



Patient using Monoset enjoys comfortable listening.

Hospital administrators will quickly recognize the unusual possibilities of this new RCA Radio and Sound Distributing System as a substantial income producer for the hospital.

For any size hospital—New or old

The most modern and efficient system for hospital use. Because the compact centralized control unit can be located at any convenient point in the building, installation problems are greatly simplified. A special clock automatically controls daily program scheduling—requires no operating personnel.

It provides four separate radio reception channels—additional channels can be added. Patients in bed using a pull-cord selector choose the programs they desire. Patients listen to programs on either Monoset or Pillow Speaker—do not disturb adjacent patients. Bed outlets can be installed in private rooms and wards.

Pays for itself—here's how!

Let's take an example. Based on a rate of 35 cents per day, per bed outlet, assuming only one-third of total number of outlets are in use, a 200-bed system would bring in an annual income of about \$8,500. Approximate current cost of complete installation is less than \$8,000.

The original investment is recovered in less than a year. The RCA Revenue Producing Radio and Sound Distribution System provides highly profitable additional revenue per bed thereafter.



Dotted lines indicate position of Pillow Speaker.

Act Now—for immediate and future benefits. This RCA Hospital Radio and Sound Distributing System may be purchased through an extended *time payment plan*. Factory service available through the RCA Service Co., Inc. For complete details see your RCA Sound Products Distributor, or write: Sound Products, Dept. 97D, Radio Corporation of America, Camden, N. J.



SOUND PRODUCTS
RADIO CORPORATION OF AMERICA
ENGINEERING PRODUCTS DEPARTMENT, CAMDEN, N. J.

In Canada: RCA VICTOR Company Limited, Montreal

NEW...IMPROVED

American DeLuxe



EASY TO STORE!

EASY TO OPERATE!

SOLVES CLEANING PROBLEMS ON:

- Wood Floors
- Rubber Tile
- Asphalt Tile
- Linoleum
- Terrazzo
- Concrete
- All New Compositions

Send Coupon Today!

New.... **RANGE OF SIZES!** Solve your floor cleaning problems with the new improved American DeLuxe ...new sizes, 14", 16" and 19" brush spread. Ample power for all floors... saves time and labor in scrubbing, scouring, steel wooling, polishing, buffing, disc sanding... maintains full brush speed on any floor.

New.... **ADJUSTABLE HANDLE!** Can be set at vertical for storing, or proper angle for tall or short operators. 90° swing. Easily detached for storing or transporting. Has Safety-Grip Switch for positive off-on action... prevents machine from starting accidentally when plugged in.

New.... **MAIN FRAME...** with new easily replaceable rubber bumper guard.

New.... **CORROSION-RESISTANT WIDE-MOUTH TANK...** optional equipment for all models. Capacity 15 quarts. Finger-tip control adjusts flow of liquid distributed through newly designed "Spray Feed" metal backed scrubbing brush. American-built dependability. Feature by feature —an ideal machine to keep floors *right*—at *low cost*!

SINCE 1903

AMERICAN FLOOR MACHINES

The American Floor Surfacing Machine Co.

546 So. St. Clair St., Toledo 3, Ohio

☐ Please send illustrated bulletin and prices on new American DeLuxe Maintenance Machines. No obligation.

☐ Please arrange a FREE demonstration of the new American DeLuxe Maintenance Machine. No obligation.

Name

Street

City State

Ideal for hospitals!

Englander- *Airfoam**



Press down on Airfoam. See how resiliently it responds to the pressure of each finger, molds itself to your hand. In the same way, it meets each bodily pressure and movement, offering complete and comforting support.

Englander
AMERICA'S MOST LUXURIOUS MATTRESS

Only Englander makes a Mattress of Goodyear's Airfoam

GOODYEAR
THE GREATEST NAME IN RUBBER

Two great names, Englander and Goodyear, combined to produce this modern miracle in sleeping comfort. Its benefits to the patient in restful ease are matched by its savings to management in maintenance and replacement.

On the basis of service and long life, Englander's mattress of Goodyear's Airfoam is the cheapest mattress you can buy—far cheaper than any innerspring mattress at a comparable price. It is available to hospitals in 3-inch and 4½-inch thicknesses. The cover is 8-oz. government standard, sanforized ACA, with rustproof zipper, which permits cover to be removed for laundering.

Airfoam is Goodyear's exclusive product, made of all natural latex, and can be had only in an Englander mattress. Available through hospital supply dealers.

For further information, write

THE ENGLANDER COMPANY, INC.

Contract Dept., 2447 W. Roosevelt Road, Chicago 8, Illinois

*TM The Goodyear Tire & Rubber Company



**They eliminated rivets
to give you a smooth interior!**

**Recent Improvements
by American
ADD
EXTRA EASE
EXTRA SAFETY
To Sterilizer Operation**

**Smooth, welded end ring of MONEL
simplifies cleaning, helps prevent leakage**

No more rivets! No more solder! Welded, forged end rings of solid Monel® are now standard on all 16" and 20" Monel pressure-type sterilizers made by AMERICAN STERILIZER COMPANY.

Think what this means in added convenience, extra protection!

NO CREVICES

The new end ring permits joining the inner Monel shell and the Monel steam jacket shell in an all-welded construction.

With rivets eliminated, the inside of the collar is perfectly smooth, always easy to keep surgically clean. What's more, the danger of leakage around rivet holes is ended.

WHY MONEL?

Monel — the standard metal for many types of hospital equipment such as laundry machinery and laboratory apparatus—is used because it is stronger and tougher than structural steel. Because it is non-rusting and corrosion resisting. Because it stands up against heat, steam, moisture, and the corrosive action of acids, alkalis, detergents

and hospital solutions.

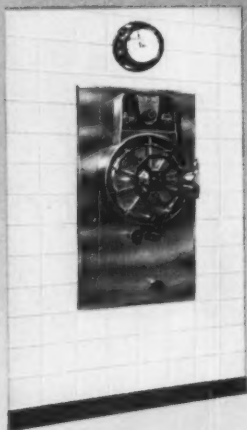
Solid metal through and through, Monel does not chip or peel. It has no surface coating to wear away. You get solid metal with solid advantages—and every one adds up to increased protection, long service life and reduced maintenance expense.

NEW CONTROL

In these sterilizers, you also get American's new "Cyclomatic Control." It is designed not only to simplify operation, but to guarantee complete sterilization. Nurse merely loads, sets timer and selector, turns starting valve. The entire sterilizing cycle is automatically governed. When buzzer sounds, nurse turns valve to "Off" position, and removes finished load. There's no guesswork, no lost motion, no wasted time.

GET ALL DETAILS

For full information about Monel pressure-type sterilizers with "Cyclomatic Control," write AMERICAN STERILIZER COMPANY, Erie, Pa. The material you'll get in return can show you the way to save both minutes and money in your sterilizer room!



THIS BUILT-IN CYLINDRICAL pressure-type sterilizer is one of American Sterilizer Company's new units featuring "Cyclomatic Control." (See description in text.) Other features include welded, forged end ring of Monel, and sterilizing chamber, steam jacket, trays and slides of the same long-lasting, corrosion-resistant metal.



LONG LIFE • CLEAN PACKS
SOLID CORROSION RESISTANCE
LOW AMORTIZATION COST
LOW MAINTENANCE COST
EASILY CLEANED
FREEDOM FROM RUST
FREEDOM FROM DECONTAMINATION
PROVED PERFORMANCE

Monel
*...A Good Bet
for Sterilizers*



THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street, New York 5, N. Y.

does **TALK** work for you?



Birthday Cakes Talk

for Strong Memorial Hospital! Every patient who has a birthday while at the Strong Memorial Hospital, Rochester, N. Y., receives a birthday cake with the compliments of the hospital. How the patients and their families love it! Dietitian G. Gwendolyn Taylor says her Dietary Department and the Hospital have won a great deal of praise through this special attention.

Talk about saving money! "Plastic food bags help us cut food costs and save money dozens of ways," reports Winifred Eliason, Greenfield-Mills Restaurants, Detroit, Cleveland, Columbus, and Cincinnati.

"For example, we use these bags to cover trays of vegetables and fruit when we store them in the refrigerator. They are also invaluable for keeping leftovers."





So Fresh

THEY TALK ABOUT YOU ALL THE TIME

They're *fresh* all right! Post's Individual Cereals just can't stop talking about you . . . for you. They give patients and employees eight examples of your infinite variety. They tell the treasurer of your money-saving ways. They impress doctors with your care in sanitation. And here's how they do it!

Offer Variety!

There are *eight* Post's Individual Cereals—one to please *every* taste.

Cut Food Costs!

Post's Individual Cereals save money. The 1-oz. individual-serving packages give you rigid portion control. Unopened packages not desired by patients can be returned to stock and served again.

Stay Fresh and Clean!

Post's Individual Cereals have sealed protective wrappings that seal their freshness in—lock moisture out—prevent contamination.

Familiarity Breeds Contentment! Patients—and employees, too—are naturally pleased when you serve the same brands they enjoy in their homes. So if you want to get folks talking for your fine food, serve famous products like Maxwell House Coffee, Instant Postum, Jell-O Desserts, and all the other fine General Foods Institution Products. Your folks *know* they're good. They've enjoyed them for years and years.



ALL THIS AND PRIZES, TOO!

Post's Individual Cereals, like almost all General Foods Institution Products, are packed with valuable coupons. You can redeem these coupons for more than 1,400 prizes for hospital or personal use. Write today for free Prize Catalog: General Foods Institution Prize Dept., Box 121, Dayton, Ohio.



TALK ABOUT GENERAL FOODS!

This is the St. Mary's Hospital in West Palm Beach, Florida. The photo at right shows you some of the 3000 Weldwood Standard Flush Veneer Doors, specified by architects Henderson and Volaw.



Choose the
**WELDWOOD
STANDARD DOOR**
that gives you
CUSTOM-MADE PERFORMANCE

Hospital Officials and their Architects are quick to recognize the important advantages of the Weldwood Standard Flush Door.

HERE's a flush door that combines striking eye appeal with qualities every hospital administrator is looking for. The Weldwood Standard Flush Door is available in a variety of high quality domestic and imported veneers for which United States Plywood is famous.

In addition, the door's unique mineral core gives you:

INCREASED FIRE RESISTANCE. The core is the same material used in the famous Weldwood Fire Door,* and provides substantially greater fire protection than the conventional lumber core door.

INCREASED RESISTANCE TO FUNGUS AND DECAY. The Mineral Core is permanently resistant to fungus, decay and termites. Weldwood Standard Flush Doors are made to last the life of the building.

INCREASED INSULATION QUALITIES. A Weldwood Standard Flush Door with weather stripping in an exterior opening provides more insulation than an ordinary door combined with a storm door.

GUARANTEED NOT TO SHRINK OR WARP.

Installed in an exterior opening, a Weldwood Standard Flush Door has been in constant use for more than five years. A daily performance record reveals *no indication of warpage or any change dimensionally, either in thickness or perimeter of the door.*

INCREASED STRENGTH AND DURABILITY.

Resting with an unsupported span of 34", the Weldwood Standard Flush Door withstood a total load of 8000 lbs. for 2 hours, with a deflection of only 1/2". *When the load was removed, the door returned to its original flat shape.*

Qualities like these mean more door for your money. Your architect, local dealer or builder can give you full details. Or, a letter to us will bring you comprehensive specifications and data. Get the whole story on this Standard Door that gives you custom-built performance.

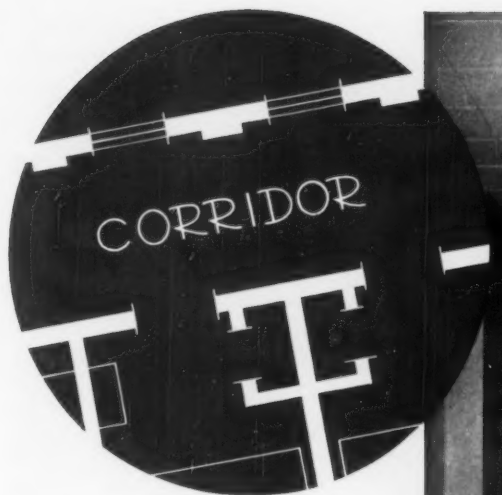
*FOR MAXIMUM FIRE PROTECTION specify the Weldwood Fire Door...the *only* wood faced fire door approved by the Fire Underwriters for Class B openings.

UNITED STATES PLYWOOD CORPORATION

55 West 44th Street, New York 18, N. Y.

Distributing units in Albany, Baltimore, Boston, Brooklyn, Buffalo, Chicago, Cincinnati, Cleveland, Detroit, Fresno, Glendale, Hartford, High Point, Indianapolis, New Hyde Park (L. I., N. Y.), Los Angeles, Milwaukee, Newark, New York, Oakland, Philadelphia, Pittsburgh, Portland, Ore., Richmond, Rochester, San Francisco, Seattle, Spokane, St. Paul,

Washington, D. C. Also U.S.-Mengel Plywoods, Inc., distributing units in Atlanta, Birmingham, Dallas, Houston, Jacksonville, Kansas City, Kans., Louisville, Memphis, New Orleans, San Antonio, St. Louis, Tampa. In Canada: United States Plywood of Canada, Limited, Toronto. Send inquiries to nearest point.



How to stop corridor noise



Sound conditioning is important in hospital corridors. Noise occurring in this busy area reflects off every hard surface—the floors, the walls, and the ceiling—and spreads into adjoining rooms and wards. There, it distracts doctors and attendants at their work and disturbs patients. By installing an acoustical ceiling, corridor noise can be controlled.

Armstrong's Cushiontone is ideally suited for corridor noise-quieting. This low-cost fiberboard acoustical tile absorbs up to 75% of all noise that strikes its perforated surface. Cushiontone is attractively finished with washable white paint. It is also available with a special paint finish, approved as fire-resistant. The 484 holes in each square foot of Cushiontone are cleanly drilled—do not attract dust or dirt. Even frequent repainting will not clog these holes to impair Cushiontone's noise-quieting efficiency.

Elsewhere in the building—in the foyer or offices, for instance—Armstrong's Travertone is recommended for its beautiful fissured finish. Armstrong's

Corkoustic, a low-density cork material, is ideal for kitchens, hydrotherapy rooms, and similar high-humidity areas. Where extra high sound-absorbing efficiency is required, Armstrong's Arrestone can be used, at slightly higher cost. Arrestone's enameled metal-pan units can be removed easily to provide access to piping and ventilating ducts. Both Travertone and Arrestone are incombustible.

Whatever your sound-conditioning problem may be, there's an Armstrong acoustical material to solve it. Consult the Armstrong acoustical contractor located in your area.



Free booklet, "How to Select an Acoustical Material," contains important facts about sound conditioning. Write to Armstrong Cork Company, 5704 Stevens St., Lancaster, Pa.



ARMSTRONG'S ACOUSTICAL MATERIALS

CUSHIONTONE®

TRAVERTONE*

CORKOUSTIC®

ARRESTONE®

*TRADE-MARK REGISTRATION APPLIED FOR

St. Francis Hospital Claims Capacity and Cleanliness of **GAS** Equipment Indispensable



St. Francis Hospital, Lynwood, California.
Mother M. Noella, Mother Superior

Sister Mary Wilma, Dietitian, Supervises Food Service



SINCE 1945 the Gas Equipment in the St. Francis Hospital Kitchen has been in constant service, yet its efficiency and cleanliness are just as apparent as when it was installed. That's why the hospital management calls its Gas Cooking Tools indispensable.

In planning the kitchen, the architects arranged the Gas Equipment so that food preparation could be carried out in assembly-line fashion, with many operations going on simultaneously. The method assures that serving deadlines will be met regardless of the occupancy of the hospital.

The productive capacity and versatility of Gas

Cooking Tools facilitate the volume preparation of food at St. Francis Hospital. As Chef Tony Boutet points out—"No other fuel I have used gives such a wide range of cooking temperatures. No other is so quick-acting or so clean."

With this background of experience the administrators of the hospital have already selected additional Gas Cooking Tools to provide for expanding food service requirements. Your Gas Company Representative will show you how you can make similar improvements in your food service operations—call him soon.

AMERICAN GAS ASSOCIATION 420 LEXINGTON AVE., NEW YORK 17, N. Y.

Island arrangement facilitates food preparation with these Gas Cooking Tools:
heavy duty ranges, steamers, steam-jacketed kettles, continuous
toaster, deep fat fryer, broiler



MORE AND MORE...

THE TREND IS TO GAS

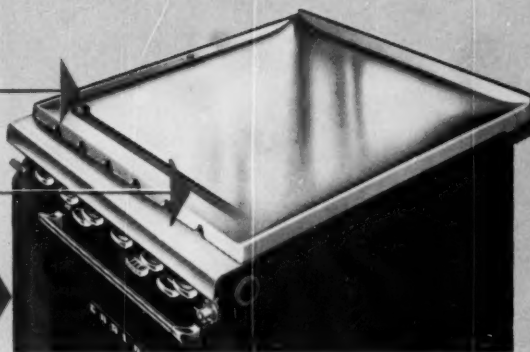
FOR ALL
COMMERCIAL COOKING

New! **An Even Greater Fry Top Range by**
GARLAND *the Leader*

**New Higher Edges
 reduce spill-overs!**

**New Front Drain Channel
 for easier drainage!**

**New Grease Container
 for greater convenience!**



**THREE Outstanding New Features...
 PLUS bigger frying capacity . . .
 It's the NEW Garland Fry Top Range!**

New higher edges provide greater depth for griddle and reduce spill-overs! *New wide drain channel* extends across the front. The griddle surface slopes slightly toward the channel for better drainage. *New construction* gives you greater frying area, greater frying capacity! *New, big capacity grease container*, for added convenience, fits on front of range. Readily accessible, it lifts off easily for quick emptying of grease.

Again Garland—the leader—with all these important new improvements, moves still farther ahead in value! Before you buy, it pays to see your Garland dealer! See Garland and compare!



New Model 47-29 CX



All Garland units are available in stainless steel and equipped for use with manufactured, natural or L-P gases.

Judged Finest by A.S.I.E.

GARLAND* *THE TREND IS TO GAS*
 FOR ALL COMMERCIAL COOKING

**Heavy Duty Ranges • Restaurant Ranges • Broilers • Deep Fat Fryers • Toasters
 Roasting Ovens • Griddles • Counter Griddles**

PRODUCTS OF DETROIT-MICHIGAN STOVE CO., DETROIT 31, MICHIGAN

*REG. U. S. PAT. OFF.



The Castle Explosion-Proof Safelight shown in a composite action photograph

Why operating teams like this flexible, explosion-proof *Castle* Safelight

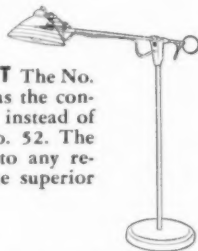
THE SURGEON BECAUSE: He gets the exceptional quality of light he expects and wants, just where he wants it, and *when* he wants it—even *when the nurse is not experienced.*

THE ASSISTANT BECAUSE: The novel optical system reduces shadow effects and *his helping hands* do not interfere with the surgeon's light.

THE SURGICAL NURSE BECAUSE: Quickly, as easily as pointing her finger, she can point the light just where the surgeon wants it. With universal focus the light is correct the instant she directs it.

THE ANAESTHETIST BECAUSE: He gets proper, color-corrected light for quick *perception of cyanosis.* He also knows that the Castle Safelight is explosion-proof and approved by the Underwriters' Laboratory for use in Class 1, Group C, Hazardous Locations.

CASTLE NO. 51 SAFELIGHT The No. 51 explosion-proof Safelight has the conventional counter-balanced arm instead of the pantograph arm on the No. 52. The lamphead raises, lowers, tilts to any required angle. It gives the same superior quality illumination.

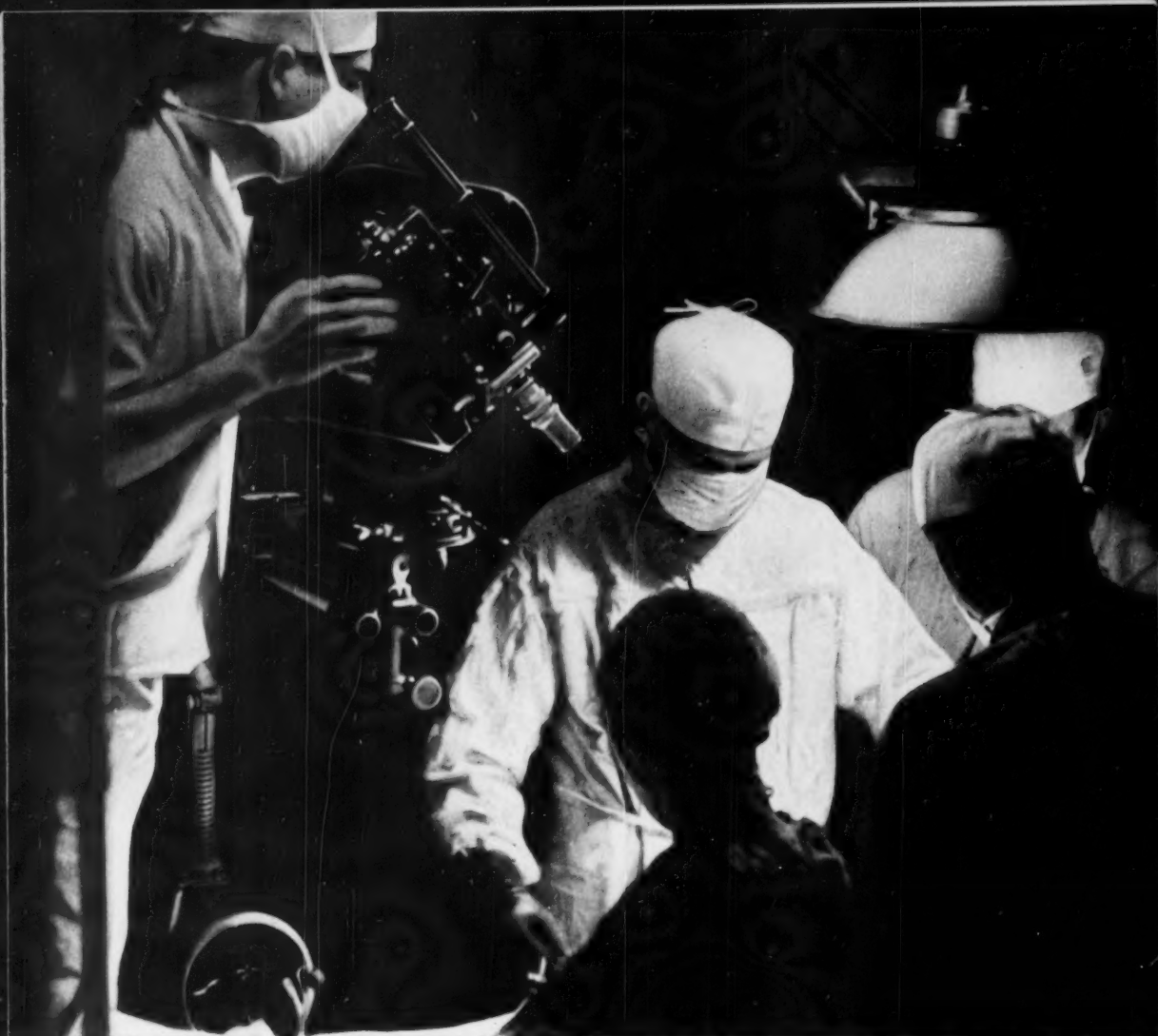


EMERGENCY POWER UNITS AVAILABLE

Consult your dealer. For catalog write Wilmot Castle Co., 1271 University Ave., Rochester 7, N. Y.

Castle

LIGHTS AND STERILIZERS



Another D&G Service

This operation is being recorded by a motion picture camera so that surgeons all over the world may learn by observing, at close range and in actual color, the skilled technique of a leading specialist.

As early as 1928, Davis & Geck recognized the value of visual education in surgical instruction. Since then, D&G has produced more than 200 films for the medical profession demonstrating the fundamental principles of surgery and the techniques of leading specialists.

This D&G Surgical Film Library is one of the largest and most diversified of its kind and has been built up solely as a service to the surgical profession. The films are in constant demand and are loaned without charge to medical societies, colleges, hos-

pitals and nursing schools throughout the world. The ambitious film production schedule being carried out by Davis & Geck is made possible only by the continuing support of surgeons and hospitals. D&G is proud of this professional cooperation and pledges a continuing program in surgical films as well as in the production of the best surgical sutures obtainable.

A complete catalog of films is available on request.

DAVIS & GECK, INC.

57 WILLOUGHBY STREET
BROOKLYN 1, NEW YORK



SUTUREGRAM

NUMBER SEVENTEEN IN A SERIES

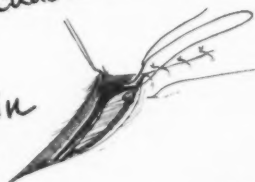
Suturing on the Face

1. To avoid scarring...

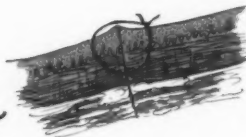


(a) Never hold skin with forceps, pressure causes necrosis

(b) Always handle cut skin edge with fine hook



2. Skin suture (fine silk or nylon) should pass through deep dermal layer.



3.



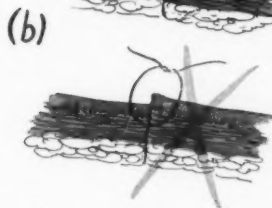
(a) Subcutaneous muscles of expression are sutured with fine catgut, inverted knot..

(b) Knot tied just beneath skin tends to be extruded



SUTUREGRAM

NUMBER SEVENTEEN (CONTINUED)



When suturing skin of uneven thickness, suture should pass through both sides at same depth (a)

5. Avoid devitalization of skin angles by using intradermal sutures



With lip, alar border or eyelid, first suture should restore continuity of margin

7. Use catgut for suturing mucous membranes and nasal lining.



Davis & Geck, Inc... and only

Davis & Geck Inc. makes **Atraumatic® Needles**

The term Atraumatic is a trade mark of Davis & Geck, Inc. It applies only to needles offered to the profession by D&G.

The construction of the D&G Atraumatic Needle provides special advantages that are not duplicated by any other brand of needle, even though that needle may be erroneously referred to as "Atraumatic."

D&G advanced the development of the Atraumatic needle principle and now produces a complete range of sizes and styles to meet virtually every situation where minimum trauma is essential.

Remember, if you want Atraumatic efficiency and quality, make sure that you are using *D&G Atraumatic Needles*. A few of the outstanding Atraumatic features are listed at the right.



1. Needle of practically the same diameter as the suture, forming a smooth, continuous unit.
2. Positive anchorage of suture in needle.
3. Swaged-on portion provides a sleeve of exceptional strength with no projecting edges.
4. Flattened area on all needles to prevent turning in the needle holder.
5. Each suture needle combination developed in collaboration with recognized authorities—represents the consensus of professional opinion in its particular field.
6. A comprehensive variety to meet virtually every surgical need.



SUTURES

"This One Thing We Do"

DAVIS & GECK, INC.

57 Willoughby Street

Brooklyn 1, New York

White Knight

Hospital Garments

Manufactured by
WILL ROSS, INC.
offer more

Comfort

Durability

Convenience

Economy



WILL ROSS, INC.

Manufacturers and Distributors of Hospital and Sanatorium Supplies and Equipment

MILWAUKEE 10, WISCONSIN



What would his chances be... in case of FIRE?

In case of fire, his chances might not be too good in many hospitals today.

Each day there are *three* fires of record in hospitals and institutions, and in those where fatalities occur an average of *five* lives are lost per fire! Isn't this proof positive that many trusted precautions are not adequate protection at all?

Unfortunately, too many people responsible for protection rely completely upon the elimination of ordinary fire hazards, important as this is. All too many more depend upon "fireproof" construction. Two facts show this to be false confidence: "Carelessness with matches and in smoking" continues to be the greatest cause of fires . . . and so-called "fireproof" buildings continue to become furnaces for flammable contents.

What most people ignore is that, regardless of the cause of fire, regardless of the building construction, it is the *proper control of fire from the first spark that constitutes full and adequate protection against fire.*

Needless loss of life and property can be prevented by checking fire at its source, whenever and wherever it

starts, night or day, automatically, with a Grinnell Automatic Sprinkler System. Seventy years experience shows that practically 100% of fires starting in buildings protected by Grinnell Automatic Sprinkler Systems are extinguished before doing material damage. Fire experts will tell you that your best protection against fire in any building is automatic sprinklers.

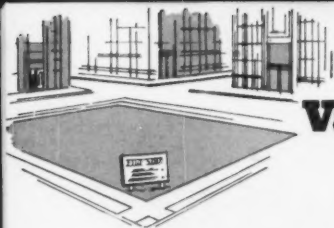


SEE THAT GRINNELL SPRINKLER HEADS ARE ON GUARD

In hospitals, as well as in schools, hotels, theaters and factories, there is a moral obligation upon management for the utmost in protection of life. For your own sake be sure the hospital for which you are responsible is protected with the famous Grinnell Automatic Sprinkler heads—your assurance of positive, automatic protection against fire. Grinnell Company, Inc., Providence, Rhode Island.

GRINNELL

FIRE PROTECTION SYSTEMS



Vacant Lot *Today...*

Hospital *Tomorrow*



When *Speed* **is the Need...**

Use CECO Open-Web Steel Joists

One day you pass a new building in the making—ground is broken—foundations are in. Then, in just a short, short time, where once there was a vacant lot, there stands a gleaming hospital, spick-and-span new. Chances are it was constructed with Open-Web Steel Joists, for that's the fastest way ever to build. There's no temporary formwork necessary... nothing to take down later on. Open-Web Steel Joists are self-centering... are placed on the wall structure and right away rib lath can be laid and

concrete poured to form the floor. And while all this is going on, other building trades can be on the job doing their special work such as installing steel windows, plumbing and heating. So, when speed gets the call, specify CECO OPEN-WEB STEEL JOISTS. They are fabricated to exact size, come to the job tagged, ready to install... provide low cost fire resistive structures. Ceco assures you fast service from five plants: Birmingham, Chicago, Houston, New York and Wheeling, W. Va.

CECO STEEL PRODUCTS CORPORATION

General Offices: 5601 West 26th Street, Chicago 50, Illinois

Offices, warehouses and fabricating plants in principal cities

**CECO
STEEL**

®

In construction products **CECO ENGINEERING** *makes the big difference*

Enduro[®]

STAINLESS STEEL

Mobile food conveyors are but one of the established applications for stainless steel in hospital service. This bright, sanitary metal is ideally suited for such equipment. It is virtually immune to wear, is easy to clean and to keep clean, does not contaminate metallically, requires little or no maintenance. More hospital uses for ENDURO Stainless Steel include autoclaves, stretchers, operating tables, surgical instruments, sterilizers, utensils, cabinets, kick-plates, ornamental trim.



AN OLD FRIEND

WITH A BRIGHT NEW FUTURE . . .



Imagine all the advantages of an entire hospital made of sanitary, easy-to-clean, long-wearing stainless steel! In composite, such an institution might exist today, says one prominent hospital superintendent.

He's referring, of course, to grouping under one roof the thousands of uses for stainless steel in the average hospital.

While the 100% stainless steel institution may be a few years away, many of its virtues can easily be included in your present buildings, to give them a bright new future.

Why not, for example, convert interior door jambs and mouldings—even doors

themselves—to tough, durable ENDURO Stainless Steel? Then unsightly nicks and scars caused by unavoidable bumping of wheeled vehicles would be a thing of the past. ENDURO entrance-ways will wear a bright, attractive look for years to come, with no maintenance other than an occasional washing.

Costs of ENDURO improvements easily can be recovered in just a few years through substantial savings in maintenance and replacement expenses.

Your equipment suppliers and local ENDURO fabricators can give you more details, or write us for full information.

✓ **CHECK ALL 10 ADVANTAGES:** Rust- and Corrosion-Resistance • Heat-Resistance • High Strength • No Metallic Contamination • Sanitary Surfaces • Easy to Clean • Eye Appeal • Easy to Fabricate • Long Life • Low End Cost • What more can be desired in a material?



For Complete Details Write

REPUBLIC STEEL CORPORATION

Alley Steel Division, Massillon, Ohio • GENERAL OFFICES, CLEVELAND 1, OHIO • Export Dept.: Chrysler Bldg., New York, 17, N.Y.

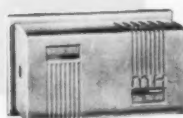
AS IMPORTANT AS THE BUILDING ITSELF

THE CONTROLS THAT GIVE HOSPITAL COMFORT



Lake County Tuberculosis Sanatorium,
Waukegan, Ill.
Architects: W. L. Pereira, Hollywood
Wm. A. Ganster, Waukegan, Ill.

THIS room thermostat looms large—and for a purpose! We are emphasizing its importance in the modern hospital. More and more, hospital administrators recognize the advantage of individual room control to maintain the prescribed temperature for rapid convalescence. And patients, likewise, appreciate the comfort that is provided.



ROOM THERMOSTAT
The Symbol of Modern
Temperature Control

In every hospital, the quality of service delivered by the heating or air-conditioning system is in exact proportion to the quality of controls governing the system. Honeywell controls are *quality* controls. Specify them.

Minneapolis-Honeywell maintains Factory and Branch Offices in all principal cities. Consult experienced Honeywell engineers on every automatic control problem.

Mail the coupon for free booklet—"Plan Your Hospital's Atmosphere".

MINNEAPOLIS
Honeywell
FIRST IN CONTROLS

MINNEAPOLIS - HONEYWELL REGULATOR COMPANY
2665 Fourth Avenue South * Minneapolis 8, Minnesota

Please send free copy of booklet "Plan Your Hospital's Atmosphere."

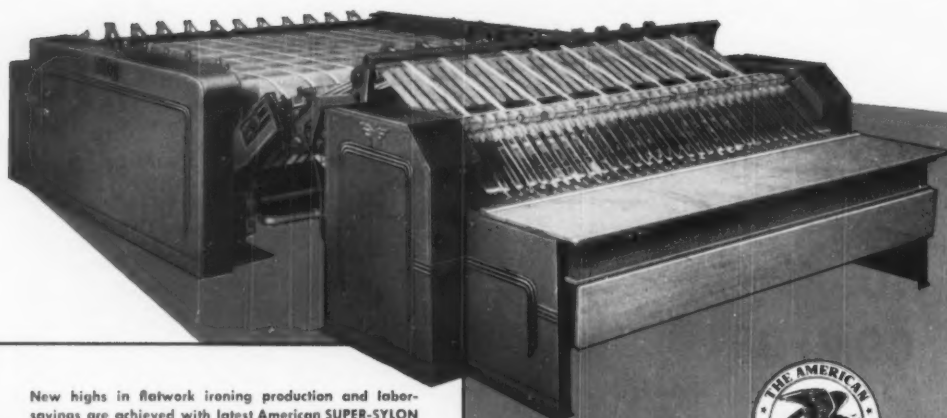
Name

Address

City Zone State

Congratulations to LAGUNA

... On its Modern, High-Speed,



New highs in flatwork ironing production and labor-savings are achieved with latest American SUPER-SYLON Flatwork Ironer and TRUMATIC Folder. SUPER-SYLON has greater production capacity than any ironer of equal size. 21% more heated surface under pressure. Ironer's chests, designed for 125 lbs. steam pressure, produce more heat for quality ironing at higher speeds. TRUMATIC Folder automatically folds large pieces twice lengthwise as they come from ironer... Only one operator, instead of previous 3-girl crew, now crossfolds and stacks entire ironer production.



PROBLEM: To plan a modern, labor-saving laundry capable of meeting greatly increased demands for clean linens at this 925-bed hospital and home for elderly persons.

SOLUTION: An American Laundry Advisor was called in. He carefully analyzed clean linen requirements for every department of hospital. He studied space and facilities available for laundry, and selected American automatic equipment specially suited for volume and type laundering required. He then submitted detailed floor-plan layout for a completely adequate, high-speed laundry.

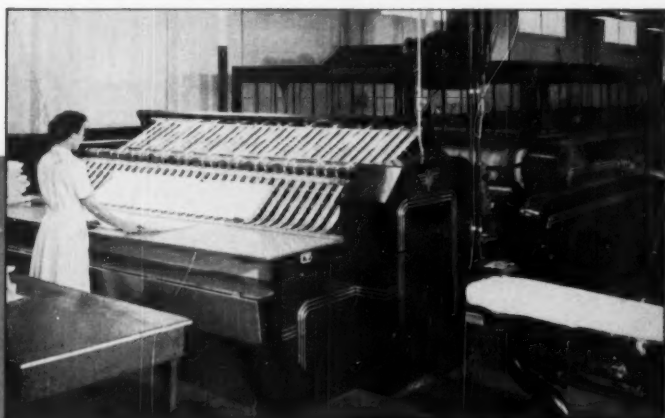
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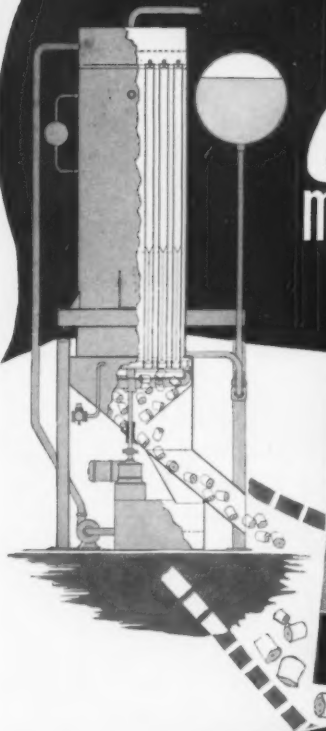
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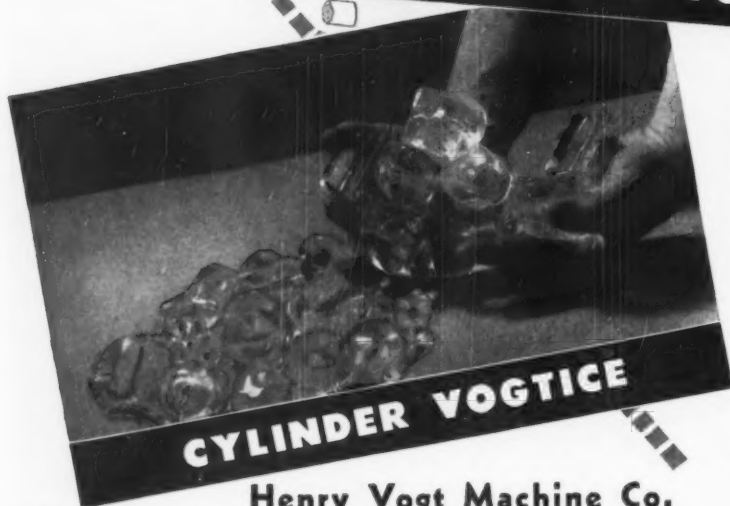
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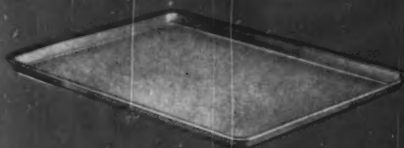
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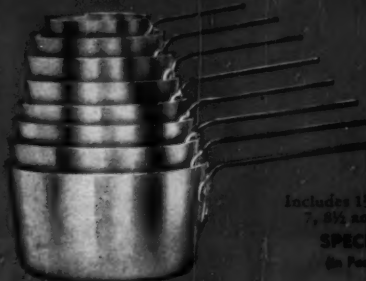


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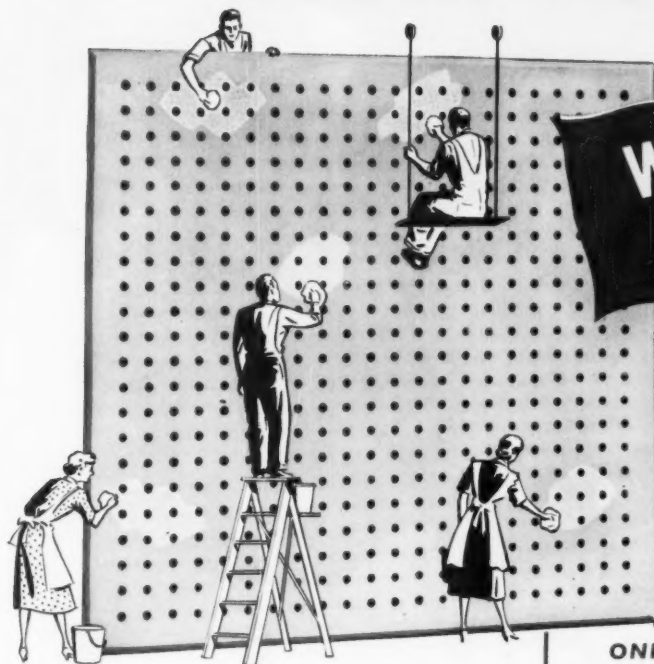
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The MODERN HOSPITAL

Small Hospital Questions

Recovery Room

Question: Is it sensible for a small hospital to consider establishment of a special postoperative recovery department in accordance with the practice now being initiated by many large hospitals?—B.B.T., La.

ANSWER: The purpose of the postoperative recovery wards that are being established in many of the larger hospitals is twofold: (1) To make certain that patients are fully protected and carefully observed during the first 24 hours following surgery. New anesthetics and surgical technics as well as new medications have made this period considerably more complicated than it used to be from the standpoint of care required by the patient. (2) "High intensity" nursing care required by patients in the immediate postoperative period makes it economical for the hospital to concentrate these patients in one area for maximum nursing efficiency.

In the small hospital it is unlikely that there will be at any one time a large number of early postoperative patients requiring high intensity nursing service, thus a safe generality might be that the smaller the hospital the less likely it is to need a special postoperative recovery ward. Also, the small hospital is naturally less likely to have space that can be adapted to this purpose. At the same time nursing units in the small institutions are necessarily smaller so that patients can be adequately cared for on general floor duty. Nevertheless, it is possible that as surgical anesthetics and nursing technics become more complicated with advancing medical science the practice of establishing postoperative recovery wards will extend to a larger and larger group of hospitals.

Staff Appointments

Question: Who should submit information to the board of trustees for its guidance in making staff appointments?—M.W., Iowa.

ANSWER: This function is ordinarily performed through a committee on appointments of the medical staff. The staff is better equipped than are lay board members to examine the applicant's record, evaluate his professional performance and judge his qualifications for staff membership. Where this staff committee functions conscientiously and

in the best interests of the hospital and the community as a whole, approval by the board of its recommendations is to be expected. In some instances, however, there may be evidence that a few members of such appointment committees are considering extraprofessional reasons in making their recommendations. For example, ruling against a well qualified applicant has been made in a few instances apparently as a means of protecting the private practice of an existing staff member or members against new competition. Also, appointment of an applicant whose qualifications are questionable might be recommended for social rather than professional reasons. Such instances as these are fortunately rare but must be borne in mind by the board in connection with this function, which is certainly among the most important responsibilities of a hospital's governing group.

Responsibility for Oxygen

Question: Is oxygen therapy a responsibility of the anesthesia or nursing department?—M.M., Ill.

ANSWER: Oxygen therapy, like any other therapeutic procedure carried on in the hospital, is primarily the responsibility of the attending physician rather than a specific hospital department. Where a medical anesthesia department exists, and this is certainly not common among small hospitals, the physician ordering oxygen therapy may delegate responsibility for its administration to the anesthesia department. Elsewhere, the actual administration technic may

become the responsibility of the nursing department—always, however, under the supervision of the physician ordering the procedure.

What Is "Nonprofit"?

Question: Is the percentage of free service a determining factor in a hospital's nonprofit status?—R.K.D., Wash.

ANSWER: According to the law in most states the basic determination of the nonprofit status of the hospital, and other eleemosynary institutions, is that it shall have no capital stock and that revenues earned in its operation shall not inure to the benefit or the profit of any person or group engaged in its management.

However, acceptance by all courts of the nonprofit status of the hospital has taken into consideration the free or charitable service rendered by the hospital. In a recent suit in one state a municipality sought to assess real estate taxes against a nonprofit hospital on the ground that patients applying for free service were investigated on their ability to pay for service before charity was extended in all except emergency cases. The municipality held that this constituted an "obstacle" to those in need of charitable service. A local court ruled in favor of the municipality but on an appeal the decision was reversed and the hospital's tax-exempt status was upheld. In rendering its decision the appeal court noted that charitable care was extended without question in emergencies and in cases found on investigation to be in need.

Training Is Desirable

Question: Should the hospital require that all medical technicians shall be qualified for membership in their respective national organizations?—D.H., Iowa.

ANSWER: The number of technicians employed in hospitals make it impossible for every hospital to require that every such employee be fully qualified. However, it is certainly desirable for hospitals to encourage employees performing technical functions to take recommended courses of training and work toward professional qualification, and wherever possible the work of all such technicians should be under the supervision of fully qualified professional personnel.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Hospital staffs also need

QUIET

FIREPROOF

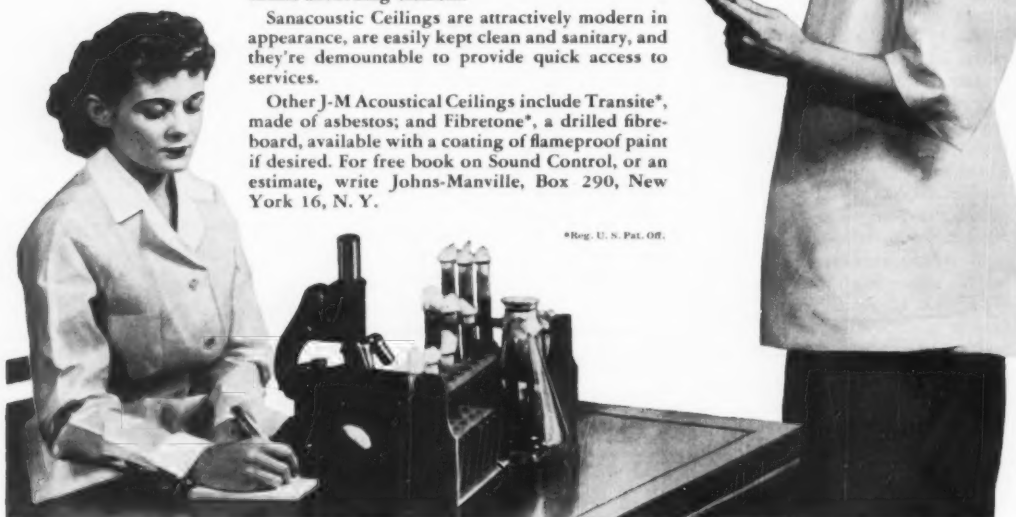
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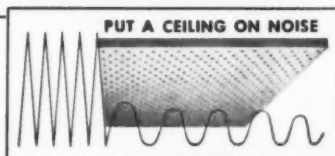
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Upstart

WE WERE brooding over the typewriter the other day when our friend Anastasia stopped in. "What's matter?" she inquired brightly. "No ideas?"

It wasn't that, we explained. We had just read a piece saying that only a few medical schools were still administering the Hippocratic Oath to graduates. We have always revered Hippocrates as a noble character and a fine moral influence, and the piece had seemed to us depressingly symbolic of the world's declining interest in morality.

Anastasia listened until the dirge ran down. Then she stood up to go. "You're only 2500 years behind," she said. "Oath was actually written by Egyptian physician Imhotep in 3000 B. C. Who's this Hippocrates?"

Improvement Is the Object

THE Southwide Baptist Hospital Association has repudiated all forms of government aid for hospitals, including by specific mention federal aid under Public Law 725. In a resolution adopted at its convention in Chicago last month, the association declared that the "allocation, grant or gift of tax funds by the federal government or any political subdivision thereof to a religious or sectarian organization, denomination or society for the purpose of constructing, equipping or operating a hospital is in violation of the First Amendment to the Constitution of the United States."

This proposition is based on the belief, also made clear in the resolution, that religious organizations build and operate hospitals "not only for the purpose of providing good hospital service for the sick but also as a means of propagating their respective religious teachings." Allocation of government funds to such a hospital is thus contrary to the principle of separation of Church and State, the Baptist group contends.

The First Amendment stipulates that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof." In a limited sense, it may well be true that the religious hospital teaches as well as heals. Whatever their faith, religious workers in hospitals are dedicated men and women. While it is certainly their aim in most cases to provide spiritual comfort rather than doctrinal instruction, there may

always be patients who want the latter as well as the former, and at some points it might be difficult to distinguish between the two.

At any rate, it does not seem likely that such activity can be interpreted to make the hospital an establishment of religion in the constitutional sense and rule out support intended to strengthen the healing function. It is hard to see how the elimination of government aid for hospital construction could be expected to help the cause of religious freedom, which the First Amendment was written to defend. On the other hand, it might easily hurt the cause of better hospital care for more people, which Public Law 725 was written to advance.

Acceptance and use of government funds by hospitals, the Baptist resolution concluded, "encourages the present trend in America toward a socialized state." Within the common meaning of the term this is probably true, and certainly most of us would be easier in our minds today if needed expansion of hospital facilities could have been accomplished wholly with voluntary resources. The calculated risk of a trend toward socialism in preference to the anarchy of unmet needs, however, is not the choice of our generation alone. "The great object of the institution of civil government is the improvement of those who are parties to the social compact," the President of the United States once declared, "and no government, in whatever form constituted, can accomplish the lawful ends of its institution but in proportion as it improves the condition of those over whom it is established."

That statement was in the President's annual message to Congress in 1825. The President was that old time socialist, John Quincy Adams.

Records and Recollections

THE Euthanasia Trial, which started out to be another courtroom circus in the grand old American tradition of Scopes, Thaw and Bruno Richard Hauptmann, failed to raise any of the moral or religious issues that were expected to rock the nation and provide rich, purple copy for Fannie Hurst and dozens of lesser geniuses who remained poised on the edge of sensation, like runners at the starting line, ready to spring into action at the drop of a Scripture. Instead of moral fireworks they got

the pathologists' findings, and instead of religious fervor they got bedside notes. As an unexpected by-product of the trial, the nation's newspaper readers got a glimpse into the detail of nursing observation and medical records procedures in the hospital, but that's all they got.

Dr. Sander was acquitted because it couldn't be established on substantial evidence that any crime had been committed. It couldn't be established that any crime had been committed because pathologists couldn't agree on the cause of death and witnesses were confused about the exact place of death in the sequence of events bearing on the case. As a matter of fact, there was even some confusion at the trial about just what death is. The point came in for extended discussion in connection with the testimony of the state's pathologist, whose opinion differed from that of an authority quoted by the defense. Observers generally muffed this one opportunity to flex their philosophical biceps.

The moral issue of mercy killing remains exactly where it was before the trial, and euthanasia enthusiasts must not be permitted to take the fact of acquittal as any indication of the jury's, or the medical profession's, or the nation's views on the subject. Whatever their conclusions about the morality of Dr. Sander's intent or conduct, however, hospital people who study the proceedings cannot fail to be impressed with the obvious technical lesson for nursing and medical personnel: Records are more reliable than recollections.

Needed Most

RECENTLY a newspaper reporter spent several days visiting the outpatient clinics at public and private hospitals in a large city to observe how patients applying for care were treated. As revealed in the series of articles which appeared in his paper, the answer was plain: It shouldn't happen to a dog, and probably wouldn't. Public hospitals pushed patients around worst of all, the reporter found out. Clinics at the larger voluntary hospitals were almost as bad. In the smaller voluntary hospital clinics, conditions were better; here courtesy was recognizable, if not rampant.

The series should be required reading for standpat types who orate endlessly about the glories of medical and hospital things-as-they-are and suspect every critical voice of being wired for socialism. It is common practice in the larger clinics, the reporter observed, for patients to be thumb-jerked from room to room and desk to desk by attendants who never speak unless they roar. Pain and fright on the part of patients are frequently ignored, and bewilderment is commonly laughed at. Hour-long waits are par, and day-long waits by no means rare. If it turns out that the patient has been waiting needlessly in the wrong department or for a doctor who wasn't coming, that's his hard luck. He's getting free care, isn't he?

Spokesmen for the clinics have had a lot to say in explanation and defense: Things aren't really that bad, in the first place; the newspaper would naturally play up unfavorable angles to make a story. The larger clinics are badly overcrowded and understaffed—a fact

which makes some waiting and confusion unavoidable. Attendants are overworked and underpaid, with resultant wear and tear on frayed nerves and tempers. Doctors donate their services and have too much to do anyway, making occasional absences inevitable and smooth consulting-room manners impractical. There is considerable justice in these defenses, of course, but it is doubtful that this fact would greatly impress the old man who squirmed with back pain in one clinic waiting room until the nurse in charge ordered him loudly to "Sit still—nobody else is complaining!"

It may be that more space and facilities and personnel and money will be needed to bring about any lasting improvement in the way people are treated in these clinics. What is needed most of all, however, waits only on response to the simple precept: *Love thy neighbor as thyself.*

Next Step

IT HAS been pointed out repeatedly that some areas which are adequately provided with general hospital beds are lacking facilities for mental and chronic diseases and tuberculosis. In one city, public officials considering the advisability of moving tuberculous patients into a communicable disease facility must measure the desperate need for tuberculosis beds against the possibilities of an epidemic. Planning authorities in another area are weighing a hospital's request for federal aid to build an addition that would be used for general beds but would release space for chronic patients. The area as a whole needs chronic and not general hospital beds, but the economy of the particular hospital in this case makes it wiser to plan the addition for general use. The law at present makes no provision for a switch of this kind, so the area may not get aid for the chronic facilities it needs so badly.

In most localities, some short-term solution can usually be found to relieve the most urgent pressures. Makeshift local solutions, however, often prove to be extravagantly expensive from the standpoint of the community as a whole. Thus the tuberculous patient who stays at home because there isn't any hospital bed for him may spread the disease to other members of his family or to neighbors and make a costly addition to the community's total health bill. Chronic patients occupying beds in general hospitals may add up to an apparent acute shortage and produce pressure for expansion far beyond what would be needed if suitable, low cost facilities for chronics were available. Crowded mental hospitals might be relieved to an astonishing degree if some means could be found for discharging all the patients whose commitments were for economic and circumstantial as well as medical reasons.

These and many other special aspects of the national hospital problem should have the kind of top level study, planning and action that have been largely concentrated on general hospitals. What we need now is a Special Care Commission—possibly looking toward Public Law 725½.



Cottage Hospital Welcomes the "TOURIST TRADE"

AS A part of the Galesburg Cottage Hospital public relations program we invited each of the men's service clubs in the community to hold one of its usual luncheon meetings at the hospital. It was to acquaint the men with the hospital that the invitation was extended. The Exchange, Kiwanis, Lions and Rotary clubs accepted the invitation and 200 men visited the hospital.

Inasmuch as service clubs have a definite time limit for meeting, which could not be observed if a general hospital tour were arranged, a specific program of exhibits was planned. What might happen to a hypothetical John Doe who needed his appendix removed was chosen as the story to be told.

It was felt this was a simple theme yet one which could be very real. It gave an opportunity to bring in the diagnostic facilities of laboratory and x-ray departments, to let the visitors see that dramatic area—the operating rooms—and to provide a display of

EVA H. ERICKSON
Administrator
Galesburg Cottage Hospital
Galesburg, Ill.

records kept for patients which would be interesting and yet not too technical. By using an anatomical doll as a "patient" receiving many treatments to demonstrate what might have happened had the appendix not been removed before it ruptured, we had an opportunity to do some health teaching.

The first arrangements to be made were for the luncheon. The main dining room, which nurses, students, technicians and office personnel use, is large enough to accommodate even the largest group, which was 75 Rotarians. The hospital employees ate in a near-by classroom using the tablet arm chairs for their meal trays. Volunteer assistance for setting up the tables, serving the meal, and clearing the dishes was provided by the local Red Cross chapter which sent out Gray Ladies and

Canteen Corps members to help. The hot cart usually used for food service to a patients' unit was wheeled to the dining room door and service to the guests proceeded without interfering with either the employees' cafeteria or patients' meal trays.

The kitchen personnel outdid its usual good work, for in each instance the service clubs decided they wanted to meet at the hospital every week in order to have such delicious meals. In itself, the pleasure of the various groups at the meal received was real and for the hospital it was most heart-warming.

Early in the plans, it was decided that the clubs must be split into small units with no more than eight persons in one group while touring. The supervisory nursing staff and faculty of the school of nursing were selected to act as escorts for the groups. An outline of the exhibits provided was prepared and discussed with the nurse guides before the first club visit occurred.



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The service clubs dispensed with their usual meeting activities. As soon as a club member appeared at the hospital he was shown to the dining room. When a group of six or eight had finished lunch it was provided with a nurse escort and started on the tour.

The groups first went to the hospital operating rooms. Here in the rotunda leading to a major operating room was a table set up with the laboratory exhibit which included the equipment necessary to take a blood count and to make a urinalysis. A differential white count slide was available under a microscope. The nurses explained the importance of these laboratory procedures in establishing the diagnosis and called attention to the actual appendix specimen indicating why a histological examination was made of the appendix.

In the operating room an appendectomy set-up was prepared with a student nurse serving as the make-believe patient. The scrub nurse, circulating nurse and anesthetist were present to explain activities, routines and procedures and to identify equipment. A chart of the cost of setting up the operating room for an appendectomy was available and explained. Opportunity to ask questions was provided and questions were encouraged.

Leaving the operating rooms, the groups were taken to a patient's room where the model used in the school of nursing served as an example of a patient who might not have had her appendix out in time. Wangenstein suction, oxygen therapy and blood transfusions were being administered. A dressing tray and penicillin hypodermic were there and nurses explained briefly the purpose of each treatment. Opportunity was taken to relate the cooperative arrangement through which the local Red Cross

1. Last group of Rotarians finishing their lunch before starting tour. Charles Gamble, member of Galesburg Cottage Hospital's board of trustees is in center foreground facing the camera.

2. One group waiting in operating room corridor to enter one of the major operating rooms.

3. Student Nurse Barbara Ward explains to the visitors what catgut is and how it is used.

provided blood free of charge through its blood program.

The next point of interest was the record room partition on which had been placed seven charts explaining some of the record work involved in giving patient care. A graph of hospital admissions and the admission office routine made up two of the charts. One concerned a patient's bill and explained what the charges were. The other four showed what a patient's chart contains, which reports are the responsibility of the doctor, how all activities performed for the patient arise from the doctor's order sheet, and how the nurses, through work records, see to it that everything ordered for a patient is provided for him.

The record display, all covering the hypothetical John Doe, caused much interested comment, and the nurses who acted as guides seemed to relish the opportunity of explaining some of the book work involved in caring for a patient.

The final stop was in the x-ray department where several films relating to diagnosing chronic appendicitis were shown, as well as such interesting films as fractures, gall stones and a twin pregnancy.

In each case tours were completed by all groups by 1:30 p.m. Each person was given a copy of a compilation of reprints of articles regarding the hospital that had appeared in the local newspaper.

The comments regarding these tours were highly favorable. Even to those who felt they knew the hospital because they had been patients or who had families who had been patients there was something new and interesting. The chart explaining operating room costs was a revelation to many. There was generally a feeling of awe and amazement at the

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4. Harriet Aberg, hospital anesthetist, explains various types of anesthetics that could be used.

5. Barbara Ward demonstrates the mayor stand setup used for an appendectomy, while Student Nurse, Phyllis Granberg, acts the part of patient.

6. Miss Aberg shows the group the method of conducting sodium pentothal anesthesia.



7. Harriet Kylander, registered x-ray technician explaining the function of the x-ray machine. 8. "Come again," Miss Erickson and a group of Rotarians leaving the elevator.



complexity of the hospital as shown by even so small a glimpse as they had. All the employees, particularly the

kitchen personnel and the nursing staff, were notably proud of having had a part in the tours. The nurses

seemed glad of the opportunity to answer questions and tell of their work.

SERVICE CLUBS TOUR OF THE HOSPITAL

Service Club members will begin to arrive shortly after 12 noon and will have their lunch first. As soon as they have completed their lunch they will start the tour in groups of not more than eight.

The exhibit provided concerns a hypothetical "John Doe" who was admitted to the hospital for chronic appendicitis and who has an appendectomy.

Take the group to surgery first. Surgery has the fracture room set up for an ordinary appendectomy.

1. Call attention to the laboratory display in the rotunda, indicating the need for C.B.C. and urinalysis. A differential white cell slide will be under the microscope. Let those who wish see it.

2. In the operating room explain that the room is set up for an appendectomy. Call attention to the two charts. One explains what it would cost to set up the room for one appendectomy. This, of course, is also purely hypothetical for all of equipment cost would not be charged to one patient. But the chart gives a good idea of some of the cost of providing hospital equipment. The other chart concerns anesthesia and indicates briefly the various types of anesthetics and the cost to the hospital.

3. On the way out, call attention to the appendix specimen and explain the need for the pathological examination of all surgical specimens.

4. Give the group enough time to ask questions and constantly urge that questions be asked. As soon as the group following appears move to the next exhibit.

Explain that state laws prevent us from permitting the group to stop in the mater-

nity division; take the stairs down or the elevator to the second floor.

On the second floor we have a demonstration of a very sick patient (Mrs. Chase)—supposedly one whose appendix was not removed in time.

1. Explain in simple words the need for the

Oxygen
Wangenstein
Penicillin

What the dressing tray is used for

2. Please emphasize that the hospital is cooperating in the Red Cross Blood Program and THAT WE DO NOT CHARGE FOR WHOLE BLOOD OBTAINED BY RED CROSS. (There is much comment in town that we make such charges. Explain that we are permitted to charge \$3.50 for each transfusion which includes the cost of the tray, equipment used, tubing used, laboratory work done and that we charge for the saline used at the same time.)

On the first floor, take the group to the record room and explain the exhibits.

Beginning at the south the posters are:

1. A display of the records that are kept for each patient about his hospital stay; these are filed and kept indefinitely. Information at the request of the patient can be released to a doctor.

2 & 3. Show details of the records. (These are the records of hypothetical "John Doe" admitted for an appendectomy.)

2. Shows doctor's part of the chart and includes:

History
Operative record

Progress notes
Anesthesia record
Consultations—with radiologist
with pathologist

3. Shows nurse's part of the chart: Explain the fact that all orders are given by the doctor and nothing can be done without these orders.

4. Shows what the patient's bill is and where the charges come from. Emphasize that BLUE CROSS paid patient's bill.

5. Shows some of the work records of the nurses that are kept in giving care to patients. Emphasize the attention paid to check and double check that patients do get what is ordered for them. Emphasize again that the doctor orders everything. Indicate that we are responsible to the government for narcotic records and that the telephone operator does get a report of patients from which she reports to those calling.

6. Graph of hospital admissions since the hospital was opened.

7. Admission routine:
Before admission—room reservation
—surgery reservation on admission—
admission form filled in and from it all other records.

Take group to x-ray. There will be films on display showing:
Colon series with appendix (our hypothetical patient did have x-ray)
X-ray showing twins
X-ray showing fractured bones

Call attention to the charts on what happens to the x-ray dollar, and on the growth of x-ray in this hospital in the last three years.

End tour in hospital library.

As Employees See Us . . . one way to find out what employees think of the hospital and their work is to ask them and use the answers to build a better personnel administration program

CURIOSITY, or the tendency to inquire into a thing, is an innate characteristic of the human mind and is demonstrated by each of us as we wonder what our associates really think of us. When unguided it becomes meddlesomeness, but when directed into a studious, critical and exhaustive inquiry, having for its aim the accumulation of new information and subsequent revision of accepted conclusions, it becomes research. This, of itself, is of little value until it is shaped into an organized program and applied to the end of producing a better finished product—a procedure which can properly be called "administration."

Admitting curiosity, seeking new information, and hoping for better administration, we asked each of our employees to complete the following questionnaire:

1. How well do you like your present job?

- (a) I like it very much.
- (b) I like it quite well.
- (c) I just accept it, neither liking nor disliking it much.
- (d) I don't like it.

2. Are your fellow employees good people to work with?

- (a) A superior group, very friendly and efficient.
- (b) All right, but not exceptional as a group.
- (c) Passable, but quite a lack of cooperation or efficiency.
- (d) Unfriendly, or poor workers, or both.

3. When new employees come to work in your department, are people friendly and helpful?

- (a) People give all the help possible and are very cordial.
- (b) On the whole, most people are quite friendly and helpful.
- (c) Are not made especially welcome and assistance sometimes given grudgingly.
- (d) Unwelcome and given little help.

4. Does the department see to it that they receive adequate starting instruction for their jobs?

- (a) Excellent instruction and follow-up give a fine start.
- (b) Instruction is quite well planned and given.
- (c) Learn pretty much by sink or swim method which wastes time and causes errors.

- (d) No instruction, or that given is confusing and inadequate.

5. How do you regard your opportunities for advancement?

- (a) My chances of promotion on merit are good, if I am qualified.
- (b) I think my chances are quite good.
- (c) Advancement would be welcome but I am not encouraged.
- (d) No chance for promotion regardless of merit.

6. Are you encouraged to make suggestions about better ways of doing things?

- (a) Suggestions are asked for and given fair and thoughtful consideration.
- (b) Not actively encouraged but may receive attention if offered.
- (c) Suggestions are not unwelcome, but, if studied, no appreciation is expressed.
- (d) Suggestions not welcomed and not considered if offered anyway.

7. Is your immediate supervisor impartial?

- (a) Very fair and impartial.
- (b) Tries to be impartial, and usually succeeds.
- (c) Occasionally lets peculiar likes and dislikes control his actions.
- (d) Has "pets" and/or picks on people unfairly.

8. Are you given a chance and encouraged to know the over-all program of your department?

- (a) Definite encouragement and planned opportunity are provided.
- (b) Not so encouraged, but no obstacle to self-information.
- (c) I have such desire but no adequate opportunity.
- (d) I am impressed that it is best to "stick to my own last."

9. If any need for correction or discipline of an employee arises, how is it handled?

- (a) Criticisms given in understanding and helpful way, never in presence of others.
- (b) Attempt is made to handle situation constructively. Failures to do so are infrequent.
- (c) Uneven—sometimes all right but more often situation is made worse.
- (d) Employee is "bawled out," often in presence of others.

10. If you have a complaint or grievance, how is it handled?

- (a) Complaints welcomed and investigated. Suitable explanation or action follows.

- (b) Usually given fair hearing and acted on or explained in acceptable manner.

- (c) Person to whom complaint made sometimes passes the buck, or otherwise fails to solve problem.

- (d) Nothing done, or resentment expressed at complaint being made.

11. Do you believe you know how your department is rating the quality and quantity of your work at this time?

- (a) My department head or some other supervisor periodically discusses my work with me in a helpful way.

- (b) I have a good idea as to how work I do is rated, but no organized plan for giving this information is evidenced.

- (c) There has been no really helpful discussion of my work with me.

- (d) I am kept in the dark as to my standing in department.

12. When you do something extra well or quickly or in other ways make an exceptional contribution to department, is what you have done recognized?

- (a) My supervisor recognizes unusual performance and knows how to give praise when earned.

- (b) Outstanding performance is fairly likely to be recognized in an encouraging way.

- (c) Praise is usually not given, or is given rather grudgingly.

- (d) No recognition of superior performance of a given task. Praise always withheld.

13. If you had a serious personal problem, could you discuss it with either your immediate supervisor or your department head?

- (a) I could discuss it and think I might get better understanding of how to solve it.

- (b) I might talk it over as one of my approaches to solving it.

- (c) I would hesitate discussing personal matter but possibly might find it helpful to do so.

- (d) I would not want to discuss anything personal and don't think I could get help if I did.

14. Are you bothered in your work by

ANALYSIS OF QUESTIONNAIRE

Sum of Columns A and B in per cent					Conclusion
Question	Acute	Chronic	Tbc.	Psycho	
1	94	99	94	91	Employees like their jobs.
2	90	92	89	81	Employees like their fellow workers.
3	90	96	88	95	New workers are readily accepted.
4	71	66	63	66	Indoctrination is fair but follow-up is poor.
5	50	49	32	81	Many jobs are considered dead ends.
6	79	86	67	76	Suggestions are not solicited but receive attention.
7	73	80	72	76	Supervisors are human but try to be fair.
8	67	61	60	63	There is need for over-all discussion.
9	70	82	69	75	Discipline fails three out of 10 times.
10	67	84	58	71	Grievances are usually handled satisfactorily.
11	69	74	67	70	There is need for discussion on work rating.
12	67	72	61	84	Outstanding performance is usually recognized.
13	51	52	41	69	The psychiatrist excels in personal counseling.
14	83	86	76	90	Conflicting instructions are relatively unknown.
15	94	90	95	100	Employees are pleased to name their employer.
16	70	92	57	75	75 per cent have less than five years' tenure.
17	Security Interest Physical Pay Recognition Promotion Counseling	Security Physical Interest Recognition Pay Promotion Counseling	Security Interest Physical Pay Recognition Promotion Counseling	Interest Security Physical Pay Recognition Counseling	Job security is considered by far the most important one factor.

conflicting orders or lack of clear division of work and responsibility?

- As free of this as seems possible.
 - This is an occasional problem but not a major one.
 - Such situations cause fairly serious problems at times.
 - This is a major problem.
15. When you tell people what department you work for, how do you feel?
- Proud to tell its name.
 - Satisfied about it.
 - Not especially happy about it.
 - Unhappy about it.
16. What is the length of your employment?
- One year or less.
 - Between one and five years.
 - Over five years but less than 15.
 - Fifteen years or more.
17. How do you rank the following factors in order of importance?
- Job security.
 - Promotion on merit.
 - Good physical working conditions.
 - Amount of pay received.
 - Credit and recognition for work done.
 - Interesting work.
 - Counsel on personal problems.
18. Consisted of a blank page under the following legend: "Use this sheet to add any comments which occur to you and which are not adequately covered by the preceding questions and answers. Print or write plainly. Do not sign."

These questionnaires were accompanied by letters guaranteeing the preservation of anonymity and requesting each employee to record his own opinions rather than those derived from group discussions. Since we desired considered opinions rather than snap judgment two days were permitted to elapse between distribution and collection. In view of the promised anonymity collection was made by lo-

cating locked ballot boxes in the various assembly areas of the hospital. This procedure obviated the possibility of accumulating answers by departments but did group them by the general subdivisions of: acute, chronic, tuberculosis and psychiatry.

Gratifying employee participation is evidenced by the fact that five out of eight completed the questionnaire and, of these, two out of five added special comments in the space provided.

In attempting to analyze the answers we gave recognition to the fact that the answers to questions 1 through 15 are arranged in four columns which can be labeled: "A—Complimentary," "B—Favorable," "C—Unfavorable," and "D—Unacceptable." Question 16 pertains to the employees' length of service and is of no particular significance when applied to the preceding 15, but becomes informative when joined with number 17 to reveal some of the changes of attitudes developing with continued employment.

The use of per cent computations permits more nearly accurate comparison of the various units and, even though over-simplification carries a danger of erroneous generalization, it appears that we are justified in considering the sum of the per cents in columns A and B as representing the total per cent of favorable answers for any given question. Application of these thoughts yields the conclusions shown in the accompanying table.

Special comments ranged from the petty to the idealistic and varied from single comments to pattern forming

repetition. Those which occurred in 5 per cent or more of the answers were all criticisms as follows:

- Shortage of supplies, 15 per cent
- Shortage of help, 13 per cent
- Need for a posted work schedule, 10.3 per cent
- Split shift, 9.7 per cent
- Sick leave policy, 8.1 per cent
- Merit Rating System, 6.4 per cent
- Pay, 5.4 per cent

Many of the comments gave indication of serious thought and expressed markedly differing points of view as demonstrated by the following:

1. "I do not see need for such questions as the one on personal problems. Most people do not care to discuss personal problems with anyone but a friend. If they happen to discuss them occasionally with department head, it is because they consider department head a friend, not because he is a department head."

2. "Please—More workers—fewer supervisors! Less red tape—more action!"

3. "These questions seem to have been drafted for the emotionally immature—with a touch of paranoia, overlooking the fact that there are a few in the world who do not work for 'promotion' and 'acclaim.' Accepting a position of any kind implies acceptance of everything that goes with it. The dissatisfied worker can always resign—if he has the nerve to do so. There is no need to attempt to change his working conditions, or the personalities of his supervisors. No one accepts a position blindly. If economic

stress is such that a worker accepts a position in spite of his better judgment—he also accepts the responsibility for adjusting *himself* to the situation. If workers would keep their private lives *out* of the office, supervision could operate more impartially with ultimately less friction caused among workers. The morale of most workers drops when it becomes a 'tradition' that Miss XYZ should not be expected to do 'this and that' because her poor dear sister just broke her wooden leg. Usually Miss ABC who ends up by doing 'this and that' does it because *her* poor dear sister just cracked one of her glass eyes and got a flat tire on her wheel chair, and she feels compelled to do everything possible to hold her job so she can earn enough to get some cement and a vulcanizing kit at the dime store to make the necessary repairs."

Thus we have obtained a generous amount of information which can be utilized to implement our personnel program and so provide better care for our patients. This we approach under the four general headings of: "conferences," "instruction," "administrative technics" and "miscellaneous" as follows:

CONFERENCES

Conferences, when properly conducted, serve to collect a variety of ideas and points of view from a number of individuals and weld them into the general policy which best serves the needs of the group. At the same time they expand each individual's knowledge of the over-all program. Our regular schedule provides:

1. The department head conference, conducted by the superintendent, and attended by both assistant superintendents and the chief of each major department in the hospital. Here we discuss and develop policy and inter-departmental items.

2. Departmental conferences conducted by the chief of the department and attended by all of the executive assistants in the department. *Examples:* (a) superintendent of nurses, with the assistant superintendent of nurses, all supervising nurses, and the nursing instructors; (b) the assistant medical superintendent with the residents and interns; (c) the chief of medical social service with all social workers.

These various conferences are attended, on occasion, by the superintendent in order that he may become familiar with the workers in each de-

partment, and absorb their ideas without distortion by transmission.

3. Individual conferences between chief and sub-chief, or sub-chief and worker as required in the regular course of business.

INSTRUCTION

Instruction includes not only the on-the-job-training which inevitably results whenever a person undertakes a task with which he is not thoroughly familiar but also organized instructional courses such as:

1. Indoctrination courses for new employees. In this connection we request the various heads and sub-heads of departments to take turns in attending the course and thus assure a continuing program of "follow through."

2. Work simplification—a course which has been so popular that we have been required to reschedule it to care for new applicants.

3. In-service training conducted for: hospital attendants and custodians by the personnel training officer; interns and residents by visiting specialists; nurses by the nursing instructors; student dietitians by the executive dietitian; student x-ray technicians by the radiologist; student laboratory technicians by the pathologist; practical nurses by trade school instructors.

Here we see a situation in which some trainees receive recognition of completion of a course by a better job with higher pay while others are expected to be content with a certificate and an inner sense of satisfaction—a situation which must, eventually, be equalized.

ADMINISTRATIVE TECHNICS

Administrative technics must be devised and applied to obtain employee understanding and cooperation if they are to result in efficient operation. They usually serve to emphasize several important aspects of personnel practices as shown by the following examples:

1. A formal inspection tour scheduled at weekly intervals and conducted by the superintendent with the assistance of the assistant superintendents, the chief of maintenance, the executive housekeeper, and the superintendent of nurses. This function is conducted in a manner calculated to emphasize efficiency, maintenance, morale, cleanliness and thrift.

2. Departmental function studies which are being conducted in one department at a time. These start by hav-

ing the employee complete a task list and proceed through careful analysis and reassignment to a job definition and, ultimately, an organization chart. In this connection, we are careful to avoid issuing the organization chart which we consider proper until we have instituted the reorganization which the chart requires.

3. Man hour studies. We are constantly searching for authenticated information on the number of man hours required for a particular job. When we encounter an acceptable report of this type we apply these figures to our operation and graph the results, a procedure which is of marked interest to our personnel and produces surprising results.

4. Budget preparation activities were assigned to all department chiefs and sub-chiefs. At the outset they were requested to supply an organization chart of their section as it was then organized and as they wished to have it organized with explanation of any additions or deletions involved. In addition they were requested to list and justify all capital outlay items which they desired and to indicate all major maintenance items which they considered to be a necessary project for the coming year, indicating the time at which it would become necessary.

These various recommendations were referred to a budget committee composed of the assistant administrative superintendent, the chief engineer, the assistant superintendent of nurses, the manager of the custodial unit, and the chief accountant for evaluation and organization. This committee's recommendations were then presented to the superintendent for further evaluation and organization. The finished product was presented not only to the governing board of the hospital but also to each committee member and department head. We believe that this procedure is beneficial in stimulating cost consciousness and spreading an overall knowledge.

5. Administrative instructions are issued in writing whenever a new procedure or policy is established. They are issued by the department chief when they affect one department only and by the superintendent when they affect more than one department. Continuation of this policy will result in an operations manual.

6. Work day studies are under way to determine the rearrangements which will be necessary to permit our patients to start their day, have their meals

and go to sleep at approximately the same hours as those observed by the average nonhospitalized individual. As a part of this program we anticipate eliminating the split shift in all except a very few positions.

7. Standardization of supplies, techniques, forms and procedures is being encouraged whenever the opportunity occurs. This has relieved much confusion and unnecessary duplication.

MISCELLANEOUS

Miscellaneous details and items which need correction but do not require establishment of new policies or administrative instruction are handled as they arise. For example, the survey indicates:

1. A shortage of linen, most marked in one particular division. Linen is being issued and more is on order.

2. A major complaint regarding failure to post work schedules a week in advance, a procedure which, the supervisors say, is made impossible by the employees' insistence on trading days. Thus, it is a situation properly referred to the interdepartmental meetings which are regularly scheduled.

3. A major misunderstanding regarding the transportation supplied to employees working in one unit indicating serious need for full discussion in one of the interdepartmental meetings.

4. Recommendations for suggestion boxes which, judging from the results of this survey, is a desirable project. This, however, must be carefully considered because once started it cannot be stopped without making the employee feel "He doesn't want our suggestions."

5. Reviewing the special comments

resulting from this questionnaire with department chiefs.

Our average employee is a friendly helpful individual who feels secure in an interesting job which he likes. He is pleased to tell people where he works and thinks that his immediate supervisor is a reasonable individual who tries to be fair and is open-minded in accepting suggestions and dealing with grievances. On the other hand he feels that he is not always given recognition for outstanding performance, sometimes wonders how his work is rated, wishes that he might have a better opportunity to know the over-all program, and feels that he has only a 60-40 chance for advancement.

These items, once recognized, are amenable to correction by group discussion, inservice training, and integrated administrative policies.

Hospitals, please note—

The Minimum Wage Law Does Mean You!

NORMAN D. BAILEY

Assistant Director
Michael Reese Hospital
Chicago

ON JAN. 25, 1950, a new minimum wage law passed by Congress became effective. Once again hospital administrators read the news with a certain sense of aloofness and a sigh of relief that their industry is marked as "a thing apart" and were thankful that the law meant no added wrinkles on already furrowed brows.

One could wish sincerely that the relief felt by the administrators was well founded and that the law would not affect them. It is true that hospitals are not engaged, by and large, in manufacture of goods which are shipped in interstate commerce and were the law limited in its effect to those businesses covered by the limitation of the statute they might be happy.

There are, however, certain wider implications and effects of the law that are not evident at first sight. In these the hospital administrator is vitally interested.

In the first place the minimum wage law will cause industry and business

to force out of employment as quickly as possible the employee whose production does not justify the 75 cent minimum wage. This will force into the labor market a group of individuals whose profitable employment is questionable. In a number of cases these individuals will be at a slightly higher level than those who now apply for the lower salaried positions in institutions. In this respect the law will make possible a more selective market for employment.

Not only may the effect of the law be to eliminate the unproductive worker but it may also force greater study of efficiency of operation in order to increase the production per man hour. Unions may prevent this except as the production increase involves improvement in machinery and techniques rather than increased effort on the part of the worker. There may be opposition even to improvement in

machinery if it means loss of jobs and a decrease in the number of workers. I venture to predict that this issue will not be pushed too far.

This attitude in industry may mean that members of boards of trustees, in active contact with industry, may expect a like tightening up in the efficiency of operation of the hospital. If it means that there is an accompanying recognition on the part of administrators of their responsibility for applying the best of industrial techniques to hospitals this may ultimately be for the good of the hospital. Communities tend to be critical of hospital unit costs. Evidences of efficient techniques of operation may help allay this criticism, unjust though it may sometimes be.

Hospital administrators and boards of trustees have been conscious of the fact that in many cases production levels for hospital employees could not stand comparison with those of factory or business down the street. The minimum wage law may serve to force

the gap even wider than at present. The increased difference in the minimum wage will affect the morale of those who sense an unfavorable comparison between their income and that of their neighbor who performs the same task in an industrial establishment.

An increase in the differential between hospital wages and industrial wages will tend to draw out of the hospital industry a group of employees who, even though they may prefer the environment of the hospital, feel compelled to obtain as much financial return as they possibly can for each day's work.

It may be well to look at the starting wages for different classes of employees in hospitals for the various sections of the country and to compare them with the 75 cents per hour minimum. At the same time we should compare the degree to which hospitals conform to the accepted standards for overtime pay and the 40 hour week. The information is taken from the American Hospital Association 1949 "Survey of Salaries in Hospitals." The figure in parenthesis indicates the amount which would be required in pay were the minimum wage law applicable to hospitals.

FALL BELOW MINIMUM

From the accompanying figures it is evident that at unskilled levels of employment hospitals in most cases fall below the minimum wage level prescribed for industry engaged in interstate commerce. Fellow travelers in this group will include many hotels and other wholly local activities. This differentiation is further accentuated when we realize that if the value of furnished perquisites is subtracted the cash wage is still less and that, unlike the hotel industry, hospitals offer little possibility of such added income as comes from tips, undesirable as the practice may be.

The significant point in any long-term thinking on minimum wage standards is that efficient operation is essential to a balanced budget. With increasing pressure to bring our wage picture nearer to the accepted standard we shall find it necessary to: (1) do a far better job of selection of employees than we have done in the past; (2) insist upon good supervision which is fundamental to efficient production, and (3) analyze every job from basement to attic with three questions in mind: (a) Is it necessary?

Regional Group	General Duty Nurses	Minimum Wage Average		
		Untrained Personnel		Clerks
		Men	Women	
New England	\$201 (\$154)	\$142 (\$154)	\$127 (\$154)	\$139 (\$135)
Middle Atlantic	\$209 (\$154)	\$135 (\$154)	\$122 (\$159)	\$140 (\$140)
South Atlantic	\$211 (\$169)	\$126 (\$164)	\$110 (\$169)	\$145 (\$143)
East No. Central	\$215 (\$154)	\$147 (\$159)	\$124 (\$159)	\$147 (\$143)
East So. Central	\$210 (\$169)	\$116 (\$164)	\$101 (\$164)	\$140 (\$154)
West No. Central	\$207 (\$154)	\$145 (\$159)	\$120 (\$159)	\$141 (\$154)
West So. Central	\$214 (\$169)	\$120 (\$169)	\$103 (\$164)	\$143 (\$154)
Mountain	\$212 (\$159)	\$142 (\$164)	\$122 (\$164)	\$148 (\$154)
Pacific	\$218 (\$135)	\$165 (\$140)	\$148 (\$140)	\$167 (\$135)

Regional Group	General Duty Nurses	Average Hours Per Week		
		Untrained Personnel		Clerks
		Men	Women	
New England	45	45	45	41
Middle Atlantic	45	46	46	42
South Atlantic	48	47	48	44
East No. Central	45	46	46	44
East So. Central	48	47	47	45
West No. Central	45	46	46	45
West So. Central	48	48	47	45
Mountain	46	47	47	45
Pacific	41	42	42	41

Regional Group	General Duty Nurses	Per Cent of Hospitals Paying Overtime in Cash		
		Untrained Personnel		Clerks
		Men	Women	
New England	44.8	49.3	47.9	34.6
Middle Atlantic	48.0	54.1	53.8	40.4
South Atlantic	39.4	44.7	42.1	30.5
East No. Central	40.3	40.3	39.7	32.7
East So. Central	43.5	44.0	42.2	34.3
West No. Central	43.1	33.2	33.7	28.7
West So. Central	32.7	36.4	36.8	25.3
Mountain	49.1	41.0	39.5	35.7
Pacific	47.3	39.9	38.9	33.5

(b) Is it being carried out most efficiently? (c) Can it be done as well by an employee whose salary status is in a lower classification?

A casual thought might well occur to many administrators that the new minimum wage law offers one more opportunity to find the union organizer in the hospital field.

Has the administrator read the law? If he has not, he should do so. He should ask himself if closer conformity to the accepted standards of the work-

ing man in the community would gain the institution needed support. He should ask himself if the increased efficiency which is forced upon his institution will not have its pay-off in an increased self-respect on the part of employees. It just may be that increased efficiency will make higher and competitive wages possible and his hospital may take its place not as a stepbrother but as a full-fledged member of the industrial family in his community.

The Modern Hospital of the Month

THE HOSPITAL OF THE MONTH

Memorial Hospital, Carthage, Ill.

L. E. WILKINSON

Fugard, Burt and Wilkinson, Architects, Chicago

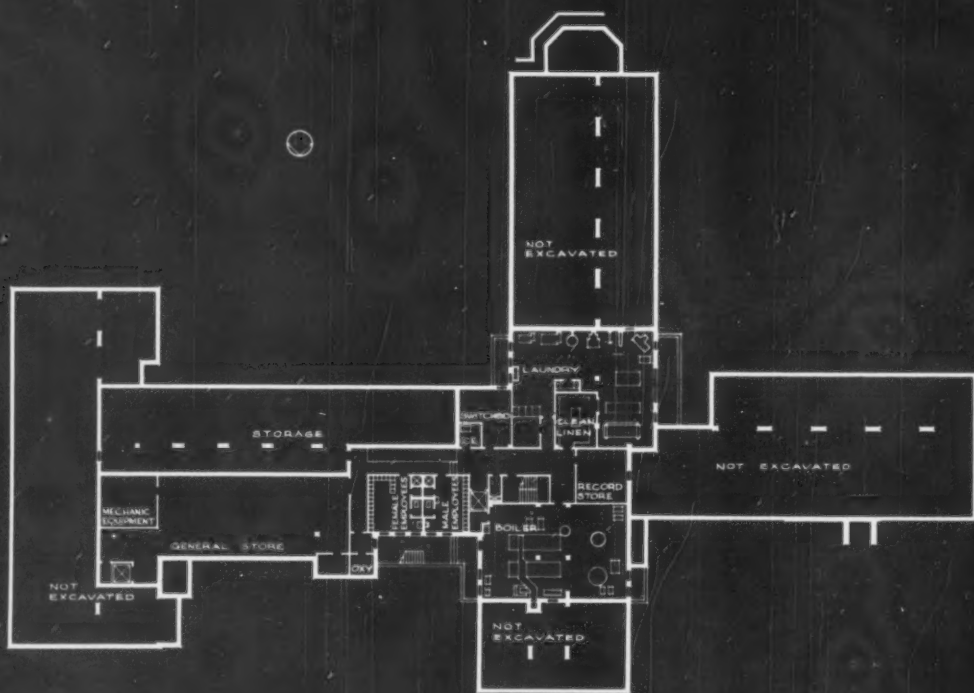
THE Memorial Hospital now under construction in Carthage, Ill., is a state and federally aided, 50 bed general hospital serving the needs of the prosperous countryside and rural communities surrounding and including the city of Carthage, some 15 miles east of the great Keokuk Dam on the Mississippi River. The raising of the local funds needed to obtain the state and federal grants was notable in that it was done by an exceptionally able and representative committee.

The site selected by the committee after consultation with the state board of health authorities and the architects

is a nearly level plot of about 5 acres lying on the south edge of the town a few blocks from the courthouse square. Access to the site is from Adams Street which ends at the center of its north boundary; another street borders the east side, otherwise the property is surrounded by residences and farm land. Since there was some possibility of the future development of an outpatient health center on the same property, the hospital was located with its principal entrance on the axis of Adams Street,

the bulk of the building lying to the south and east, thus leaving ample space to the west for the health center which could still be connected with the administration wing of the hospital.

Comparative studies of several plan solutions showed that, by taking advantage of the ample ground area available, a one-story building could be built for an appreciably lower cost per bed than could one of two or more floors even though the unit cost per square foot was somewhat higher. This



BASEMENT FLOOR PLAN
SCALE 1" = 10'

is because of the reduction in area per bed, owing to elimination of the areas required for vertical circulation. These studies also indicated that operating costs of the one-story hospital should be less because of the elimination of elevator operation, and distribution of food at one level. Nursing service can be adequately handled from two stations with a resultant operating cost saving over three nurses' stations that would be required for a two-story structure. It might be noted here that even in a hospital only slightly larger these advantages no longer exist for the single-story plan.

In the plan, business and administrative offices adjoin the entrance lobby with the nurses' locker room near by. To the east of the lobby are the laboratory, x-ray suite, pharmacy and medical record room, so located that their facilities are available for diagnostic work to outpatients, who can enter without passing through hospital corridors, as well as for the inpatients.

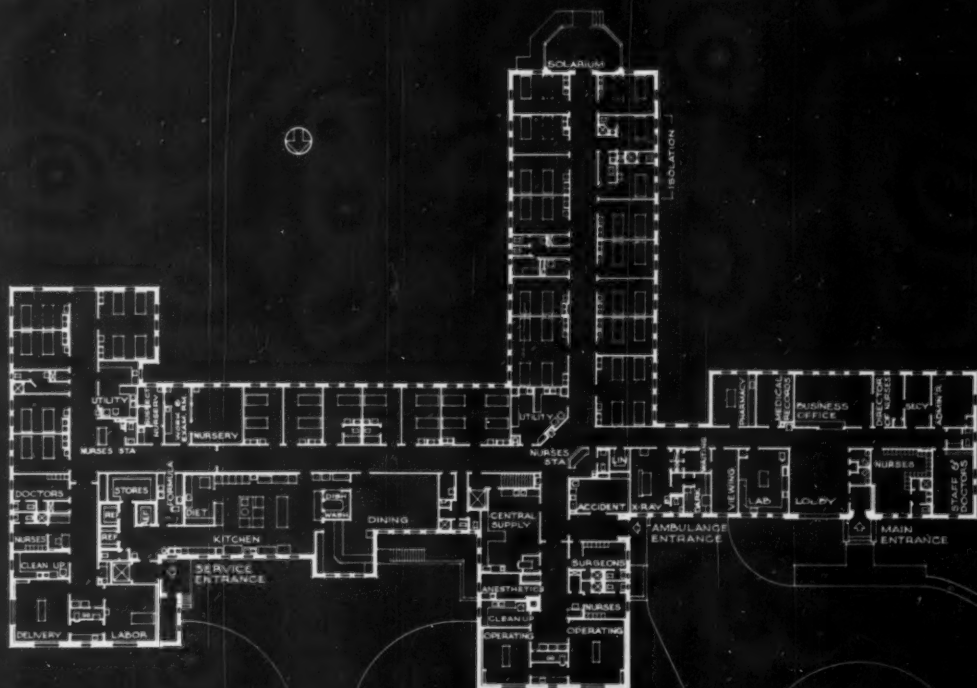
Just beyond the diagnostic group is the principal nurses' station at the in-

The hospital presented here has been selected as The Modern Hospital of the Month by an award committee which studied plans chosen for consideration by the agencies administering Public Law 725 in the various states. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.—THE EDITORS

tersection of the north-south and east-west hospital corridors. From the station there is a view of every medical and surgical patient's door and the signal light above, as well as complete control of all hospital traffic whether of visitors, physicians, patients or hospital personnel. The utility room is across the corridor from the nurses' station and is divided by low partitions into clean and dirty utility spaces with laundry chute near by.

Patients' rooms, whether single,

semiprivate or four-bed wards, are all placed away from any sound or view of service traffic, with east, south or west exposure so that each room may have some hours of sunlight each day, if desired. Two of the private rooms in the south wing are arranged with work space for isolation technic. A bedpan closet is provided in each corridor. North of the nurses' station is the ambulance entrance with adjacent accident room. The operating pavilion beyond contains major and minor



FIRST FLOOR PLAN
SCALE 0 5 10 20



operating rooms, substerilizing room, clean-up room and locker and toilet rooms for surgeons and nurses. Space is also provided for surgical supervisor's desk and stretchers.

The east end of the hospital contains the maternity section with its own nurses' station and utility rooms. The delivery suite consists of delivery room, combination labor and emergency delivery room, clean-up room, doctors' and nurses' locker rooms and space for stretchers and supervisor's desk.

The dietary department includes main kitchen from which a special diet kitchen, which includes the dietitian's desk, is separated by low partitions, refrigerators for meat, dairy products and vegetables, and a day storeroom for

package goods. Patients' meals are served by tray carts set up in kitchen. Hospital personnel is given cafeteria service in a dining room of sufficient size to handle each meal in two shifts. The dishwashing room with metal acoustic tile ceiling is between cafeteria and kitchen. The vexed question of control of infant formulas is solved by placing the formula room between kitchen and nursery corridor so that the formulas can be handled either under the dietitian's supervision or by the baby's nurse as future management may decide.

Although the entire first floor is of reinforced concrete raised above grade, only a portion of the basement is fully excavated to house the heating plant,

laundry, employees' locker rooms and ample storerooms. The remainder of the area is limited to crawl space for piping.

Supplies are received at the service entrance and taken to the basement storerooms by a freight lift. Hospital supplies other than food are withdrawn from storerooms and brought to first floor by a second lift under control of the central supply personnel. This same lift also serves for the return of clean linen from laundry to nursing floor.

The building is heated by circulating hot water to room convectors below windows. Operating rooms and delivery suite are air conditioned by separate systems. Mechanical ventilation is provided for dining room, cafeteria, kitchen, and so forth, and a separate ventilation system handles the laundry. All toilet rooms, utility rooms, bedpan rooms and the like are on their own 24 hour mechanical exhaust system. The roof is insulated throughout and provision is made for removal of heated air in over-ceiling space during hot weather.

Following is a breakdown of construction costs. Construction contracts were let in September 1949:

Number of beds	50
Total floor area	29,936 sq. ft.
Floor area per bed	600 sq. ft.
Construction contracts let including Group I equipment	\$603,896.00
Construction cost per bed	12,075.00
Construction cost per square foot	20.02

Ford Hospital to Have \$13,600,000 Addition

DETROIT. — The Henry Ford Hospital here will soon undertake construction of a \$13,600,000 addition to its present plant, it was announced last month. The new 17 story building was made possible by a gift from the Ford Foundation, the announcement said; it will house clinic facilities with a capacity for 400 patient visits a day.

Concentration of clinic facilities in the new building will make possible the release of space now used for outpatients and permit the addition of 96 rooms for single or multiple bed accommodations, it was explained, thus adding measurably to the hospital's 600 bed capacity.

Announcement of the new addition

was made by Drs. Frank J. Sladen and Roy D. McClure, chiefs of the medical and surgical staffs. Ground will be broken this summer, it was reported, and it is expected that the building will be ready for occupancy within three years. Building was planned in accordance with recom-

mendations made following a study by Dr. Basil C. MacLean. Vorhees, Walker, Foley and Smith are the architects.

The skyscraper clinic will be erected as an annex to the present main building of the hospital, directly opposite the main hospital entrance (see picture). In addition to clinic facilities in the various branches of medicine, the building will contain operating rooms, laboratories, teaching rooms, diet kitchens and staff rooms. Dining and lounging rooms for the staff will be located in a penthouse, it was explained.

Henry Ford II is president of the Ford Foundation, whose donations to the hospital now total \$30,000,000.



Architect's rendering of Ford Hospital Clinic.

PERSONNEL HEALTH SERVICE *is good business*

some of the problems that must be considered when the hospital sets up its personnel health service

HOSPITALS no longer refuse—at least in theory—to accept the responsibility for the health and medical care of their employees. Many accept this responsibility in fact. Their thesis is a simple one: To care for those members of the community who out of desire, chance or necessity are employed by the hospital is not paternalism, it is good citizenship and sound business. As such, care should be given not reluctantly but voluntarily and freely.

What constitutes good, let alone the best, medical care would be difficult to define. Since it would be no less difficult to draw a blueprint for an ideal personnel health service, the purpose of this paper is merely to discuss briefly one of many satisfactory setups and to point to some of the special problems.

PERSONNEL HEALTH CLINIC

The physical arrangements of the Personnel Health Clinic need not be elaborate. A small office and two examining rooms for a total hospital personnel of five or six hundred are all that are really necessary. These rooms require only such basic equipment as a desk, chairs, examining table and instrument cabinet, a refrigerator for biological supplies and laboratory specimens, a lavatory and files for personnel records.

Similarly, it need not be quartered elaborately and is probably best situated near the personnel office. This location is good for several reasons: (1) the close cooperation between the personnel officer and the personnel health clinic which must exist from the very inception of the service and which will be increased by physical proximity; (2) the ready accessibility of the personnel office to all the personnel; (3) the presence of a waiting room already set up, and (4) the fact that even the newest employees are well acquainted with the location of the personnel office and thus need not waste their time looking for the clinic to the exasperation of the service nurse, their department heads, and themselves.

The quality of the service will be

known by the quality of the professional staff. The physician must, therefore, be carefully chosen and will probably be most readily found among recent graduates of the house staff since young physicians now have that interest in, and basic knowledge of, preventive medicine, public health, and social medicine which are indispensable if a good job is to be done. The moderate compensation which is the due of the personnel physician is frequently welcome to these younger men who are also the most likely to have available the time that must be spent, usually about two or three hours a day.

A full-time nurse is not required for 500 employees in these days of nursing shortages. The assignment of a supervisor, particularly in those hospitals with training schools, should be seriously considered; but this assignment must not be made as an afterthought; she must be chosen because of her interest and, preferably, her experience in the public health field.

The clinic can probably best meet all demands by being open twice daily: in the morning from 8:30 to 10; in the afternoon beginning either at 12:30 or at 4 and continuing until all the patients have been seen.

The morning clinic should be attended by the personnel health physician, and might well perform the following services:

1. Do the preemployment examinations.
2. Do the periodic routine reexaminations.
3. See the patients referred from the emergency ward on the previous day.
4. See the patients who had been seen the previous day at the afternoon clinic and had been referred for consultation by the physician in charge of that clinic.

The afternoon clinic can be manned by the medical resident or the medical assistant resident. To prevent needless discussion, indifference and even occasional hostility, it must be made clear to the residents from the very beginning that the personnel health clinic is to be a regularly assigned part of their service in the hospital, and to the chief of the personnel health service that this is a *teaching* service.

Arrangements must be made for direct referral to specialty clinics of those patients for whom the personnel health physician desires or requires consultation. House officers and nurses usually prefer not to attend the hospital clinics, and visiting physicians are almost invariably willing to give their services free of charge to these professional people.

PREEMPLOYMENT EXAMINATION

The purpose of the preemployment examination is to determine if the particular employee can do the job for which he was hired and, if not, to determine his work capacity so that his services may, if at all possible, be utilized elsewhere in the institution. While this is the primary objective of this type of examination, it is not the sole one. There are others:

1. The discovery of disease in the employee for the single purpose of remedying that disease. To the tuberculous, the early discovery of tuberculosis may mean the difference between a short illness with excellent chances for complete recovery, on the one hand, and, on the other, a long hospitalization with a very slim chance for complete return to a normal life in society.

2. The early discovery of disease so that patients and fellow employees in the hospital may not be endangered. This is most important in the case of

SIGMUND L. FRIEDMAN, M.D.

Director, Mount Sinai Hospital, Cleveland

transmissible disease and is particularly evident in tuberculosis. It would be most unfortunate if a person admitted for a nontuberculous disease recovers and is discharged with a tuberculous infection acquired from an employee. This, though it may be improbable, is certainly not impossible.

3. The discovery of disease so that compensation will not be paid to an individual when such payment should not properly be charged to the institution. Tuberculosis again may be cited as an example.

It must be made perfectly clear not only to the prospective employee but to all the employees in the institution, that the purpose of this examination "is not to exclude from employment all but physically perfect and healthy applicants." (Geiger)

This does not mean that we are to have no physical standards; it means, rather, that our standards should be based on the requirements of the job. The requirements of a sedentary occupation are likely to be far different from those for the more physically strenuous positions. A case in point would be a man with a moderate to severe degree of hypertension who, assuming he had the qualifications, would be employable as a bookkeeper but might not be as a stationary fireman.

For our purposes, diseases can be classified roughly in three ways:

1. Those which are no bar to immediate proper job placement, such as symptomless hernia, latent syphilis under treatment, or compensated heart disease.

2. Those which are a bar to placement until treated satisfactorily, such as communicable syphilis or symptomatic heart disease. Patients with these diseases, or in these stages of disease, may be put to work as soon as their disability is brought under control. Many will require continued and close supervision; many can be placed only in certain jobs. But these patients should not be declared totally unfit for any type of employment.

3. Those which do not permit placement, such as active tuberculosis, intractable decompensated cardiovascular disease.

Both the personnel physician and the personnel officer must remember at all times that if the applicant is not fit for the job for which employment is sought, every effort must be made in the direction of job placement elsewhere in the hospital. Neither is it too much to expect the hospital personnel

officer to use his knowledge of the industrial community and the various governmental facilities so to steer the applicant who is rejected because of physical disability that he may find his useful place in society.

When any defect is discovered at the time of examination, the applicant must be immediately informed whether or not he is rejected. It is up to the personnel physician to do the informing for, after all, the physician who has done the examination is in the best position to make such disclosures as necessary to the employee. Again, frank discussion by the physician with the employee will do much to remove the criticism that these examinations are solely for the benefit of the employer. Discussion of these defects will also go a long way toward obtaining the cooperation of the employee in further essential study and treatment.

The preemployment examination includes, of course, a history. Here, only positive statements should be relied upon since it may be assumed that few people will say anything to hurt their chances of getting a job when that job is badly needed. In view of this, and in view of the fact that histories taken under these circumstances cannot be as good as those taken under better conditions, these histories need not be detailed. They should, however, request specific answers to specific questions concerning surgical operations, epilepsy, nervous breakdowns, tuberculosis, diabetes, heart disease, syphilis and gonorrhea, malaria and immunizations.

The physical examination will, of course, be complete and include a specific search for evidences of communicable disease. Special note must be made on the chart of the presence or absence of such communicable disease.

At the time the physical examination is done, a urine specimen should be obtained and blood for serological test should be taken. When stool analysis is indicated the reasons must be explained to the employee at the same time, so that the specimen may be obtained as soon as possible. Tuberculin tests should certainly be done on all nurses, house officers and orderlies; they should also be done on all employees working in the tuberculosis division of the hospital. The tests must, however, be done and be read only by the personnel physician who should have acquired much experience in their interpretation. Other laboratory examinations should be done when indi-

cated; the commonest will be the blood count and some of the blood chemical examinations.

The forms to be used for the recording of the history and physical examinations will be determined by the preferences of the personnel physician and the requirements of the particular service, although they should be as simple as possible. Only one point need be stressed here: In addition to spaces for the usual data, the following specific statements are necessary:

1. Whether or not the applicant possesses evidence of communicable disease.

2. Whether or not the applicant is employable.

3. Whether or not there ought to be any restrictions in the work the applicant may perform.

Finally, the record must be signed, not initialed, by the personnel physician and the assistant director or other member of the administration for, after all, the hiring of any employee is an administrative responsibility which can be assumed only by an administrative officer.

PERIODIC ROUTINE REEXAMINATIONS

Ideally, every employee in the hospital should have a health audit once a year. Practically, however, such examinations, including chest x-rays, need be routine only for those serving on the tuberculosis division (where they should be done at least semiannually) and for nurses, interns and food handlers. The reason for these periodic reviews are obvious.

Examinations of those employees in borderline health or with a past history or current suspicion of active tuberculosis may vary in frequency from every few weeks to once a year—or even less often.

EXAMINATIONS AFTER ILLNESS

It is probably unnecessary to examine every employee who has been absent from work on account of illness, assuming it were even feasible. An employee who has been ill should be required to obtain a clearance through the personnel health service, and the nurse should record the cause of illness. If the employee has been absent for a predetermined period—say three days—he should be required to bring a note from his personal physician. If he has been ill for more than seven days, if he still has a fever, if the ill-

(Continued on Page 134.)

AFTER more than two years of operating a pay cafeteria for employees, we can report that food waste has been reduced approximately 75 per cent, a greater variety of dishes is served, and complaints from employees about food have vanished almost completely. Since we have extended service beyond the normal meal hours and opened it to the hospital public, the pay cafeteria is being operated without financial loss and with positive gains in good will toward the hospital.

Our pay cafeteria was opened in November 1947, following eight weeks of study and preparation by the head dietitian and a committee of department heads. This study was prompted by a chance remark made by the dietitian at a regular department heads' conference about the spiraling cost of food. She presented facts and figures to the group at the next meeting. Initial disbelief about the costs of serving meals to employees was followed by rapid calculation of how much this perquisite really was worth in terms of cash each month, and the special committee was appointed to make recommendations.

The custom of furnishing one or more meals instead of cash is a hold-over from the days when a large percentage of the working staff of hospitals was provided complete maintenance, including quarters, meals, uniforms, and laundry. We are familiar with the sociological and economic reasons for gradual abandonment of the perquisite system. Higher standards of living and development of the automobile and other forms of rapid transportation have made it both possible and desirable for permanent employees to live away from their place of work. Progress in medical science and hospital care has created new professional and semiprofessional groups—dietitians, laboratory technologists, radiological technicians, research workers, and the like—that maintain homes and interests far broader than the uninspired confines of an employees' building or dormitory. A higher percentage of graduate nurses and aides are married and have families. Provision and maintenance of employees' quarters are no longer a financial saving to the hospital.

Inasmuch as food must always be prepared, the meal perquisite during hours on duty has held on longer than the others, but there are cogent reasons why it should be abandoned also.

Snack bar time
(between meals)
in the cafeteria
of the hospital.



Employees Pay for Meals— and like it!

DAVID LITTAUER, M.D.
Director

FRED P. RYDER
Administrative Resident
Menorah Hospital, Kansas City, Mo.

Items furnished in lieu of cash are soon taken for granted. We have mentioned the surprise of department heads, who are a cost conscious group, when the cost of furnishing meals to employees was explained to them. The employees do not take the cost of the meals into account when comparing their salaries with the earnings of those doing similar work outside the hospital.

Another reason for abandoning the meal hand-out is the difficulty of control. If a punch card is issued to each employee, or if he signs a roster, considerable clerical work is involved to keep track of the system. If no card is issued and no signature is required, who will know that an employee authorized one meal per day does not eat two, or the worker who has been promised two meals as a condition of employment does not make away with three? Our survey indicated that abuse of the meal perquisite was serious, as will be explained later.

When no charge is made for meals the hospital always takes a loss from or incurs the displeasure of special groups of individuals who are not employees of the hospital, yet who cannot be turned away at mealtimes. At Menorah, visitors who wished to eat at the hospital were directed to the business office where they purchased a meal ticket for 75 cents and presented it to the cafeteria woman at the head of the serving line. Frequently, a visitor wanted only dessert and coffee, yet paid the full cost of the meal. Private

duty nurses were accommodated by signing a daily register sheet at the head of the serving line; this was sent to the accounting office for entry on their patients' ledgers, but more than one such nurse slipped by the busy cafeteria woman at the steam table. And what did one do with the surgeon or anesthetist whose heavy schedule extended through meal hours, and who appeared in the serving line with overpowering affability? He was fed, of course, with no questions asked!

An incidental, but nonetheless real irritant, is the rôle of the meal perquisite in collective bargaining. Engineering and maintenance crews of the Kansas City hospitals are unionized. Although the business agents of their unions know all about the meal perquisite, they hopefully ignore it at bargaining time when comparing hospital wages with those paid to their people in industrial plants and business establishments, and it is necessary to go through the same explanations each year! The problem is aggravated because the hospitals themselves are not in agreement on the number of meals authorized for various duty shifts and types of work, or on their cash value.

The first step in the study was to determine the cost per meal. The hos-



The pay cafeteria has eliminated "gripes" about the quality of the food.

pital agreed to carry the overhead expenses, such as equipment, maintenance and utilities. The cash value of the food per meal and of the labor involved in preparing it was determined to be approximately 40 cents. The noon meal was worth a little more, the other meals a little less, but the committee of department heads which surveyed the problem agreed that it would be more satisfactory for pay roll purposes if an average was struck.

Each department head was requested to review the number of meals granted as a perquisite with each person in his department so that the proper cash replacement could be made. We found that all kinds of promises had been made in the past, particularly during the war years, to get people to work at the hospital, and that some of them, like x-ray or laboratory technicians, who normally would be entitled to one meal during a duty period, had been promised three meals as a condition of employment. In order to maintain good relations with employees who had been faithful to the hospital, we went along in most instances with the number of meals which each person said he was entitled to, relying upon normal turnover through the years to take care of some of the obvious discrepancies.

On the day the pay cafeteria opened, we added to each employee's pay check, an amount equal to 40 cents per meal for each meal to which he was entitled, based upon 26 duty days per month. This increased the total pay roll by 9.6 per cent. We estimated that the hospital would lose about \$30 per day, or about 10 cents per employee for our 300 full-time employees, on the cafeteria since it absorbed all overhead expenses and the cost of employing

one new person (a cashier), and since some employees would not buy back their food in whole or in part. This would be a contribution, we hoped, to better employee relations.

The menu was made more attractive by adding some à la carte items, such as sandwiches, to the usual plate lunch. Even though this might mean that the return to the hospital would be less than 40 cents per meal, we went along with it because we envisaged the possibility of less waste.

The physical layout of the cafeteria serving facilities required only minor alterations. Space was provided for sandwich making on the back bar, and a table and stool for the cashier were set up at the end of the serving line. While not as efficient as a specially designed sandwich unit, it serves the purpose admirably with little motion being wasted.

A cashier was the only new employee added. She works from 9 a.m. to 6 p.m. For the breakfast meal, a reliable counter woman serves as the cashier. In order to permit eggs and pancakes to be made on order, the hours of a woman in the nourishment section of the kitchens were changed from 7 a.m.-4 p.m. to 5:30 a.m.-2:30 p.m., with no loss of efficiency in dispensing nourishments to patients. No increase in the cafeteria staff was necessary to care for night shift workers.

Several things happened in short order which reduced sharply our estimated losses. We found that employees who had been taking full meals with all the trimmings now chose their food with care and bought only what they thought they would eat. Food waste for the noon meal, for example, dropped from 5 gallons to 1½ gallons per day. The consumption

of butter dropped appreciably since a nominal charge per patty was now being made. The practice of taking multiple drinks, e.g. coffee and milk, practically ceased since employees were paying for them and purchasing coffee or milk. Bread consumption dropped somewhat.

Losses incurred by serving staff physicians gratis were reduced. Whereas, before, the total cost of food, labor and overhead was lost, now only the overhead expenses for feeding a dozen or so members of the visiting staff each day had to be absorbed.

The decision to serve sandwiches proved to be not only an investment in good employee relations, but also a means of reducing the margin of loss on the operation of the cafeteria. On days when the plate lunch features one of the cheaper meats or fish, the demand for sandwiches is high. It is possible to sell an egg salad or tuna or ham sandwich at a reasonable price and still make a small profit, because the cost of preparation is lower than it is for cooked dishes. No one has objected to this because of the variety of sandwiches at different prices from which a choice can be made.

For these reasons, we found that an estimated loss of \$30 per day was too high. Soon other developments eliminated this deficit completely.

Menorah Hospital is situated in a residential and boulevard area without restaurant facilities in the vicinity. Although a coffee shop is included in the plans of the present expansion program, there is no space for a separate coffee shop or snack bar in the existing building. The heaviest concentrations of visitors to the hospital are outside of regular meal periods, of course, but an appreciable number is always in the building during the lunch and supper hours, and even during breakfast. It includes visitors to patients in private rooms, where visiting hours are not restricted; members of our women's auxiliary who may be at the hospital on auxiliary work; private patients of members of our staff who come as outpatients to the laboratories and other clinical service departments for diagnosis and treatment; anxious relatives who accompany emergency admissions; families who foregather on the morning of a surgical operation or during a terminal illness, and even occasional salesmen. Here is a vast

reservoir of potential friends of the hospital, who are all too frequently overlooked in our elaborate schemes for public relations in the community. How many of them do we irritate by ignoring their wants for food or a cup of coffee, or making it difficult for them to obtain it?

Shortly after the pay cafeteria opened, the administrative and dietary staffs began to receive inquiries from all sorts of people whose interests brought them to the hospital about the possibility of eating in the cafeteria during meal hours, or of buying a cup of coffee and a sandwich between regular eating periods.

Therefore, two months later the cafeteria was opened to visitors during meal hours and kept open as a snack bar between meals. (It is closed for 30 minutes just before lunch and supper to permit thorough cleaning up.) One more employee was added, a sandwich woman.

Opening the cafeteria-snack bar to visitors created a new problem: although the public relations approach of the hospital to its friends benefited tremendously, we were still absorbing the overhead costs of operating the cafeteria, and they would tend to increase because of longer hours of operation, more maintenance, and so forth. The problem was solved by modifying the straight cash system. All prices were raised 20 per cent, and \$5 meal ticket books were sold to employees for \$4. (They have recently been reduced to \$3.75, as the cost of food has declined somewhat.) In this way, we make a slight profit on visitors during meal hours and during snack bar periods, and are still able to charge employees only for the estimated cost of the food and the labor involved in preparing and serving it.

Our experiences for 1948 and 1949 in the between-meal snack bar were:

	1948	1949
Average number of people served per month.....	3,240	4,563
Average number of people served per day.....	108	153
Average gross income per month.....	\$473.23	\$893.57
Average gross income per day.....	36.42	74.47

We have not attempted to calculate exactly the net income from the snack bar because it is not possible to separate expenses from those incurred in operating the employees' cafeteria.

It should be emphasized here that these figures cannot be compared to those which obtain from a typical hospital coffee shop. They represent,



Staff physicians find the cafeteria and snack bar a great convenience.

rather, an extension of usage of dining rooms which would otherwise stand idle between regular meal hours. Many hospitals may find that they can adopt such an expedient which will net a small amount of revenue and a tremendous amount of good will if they do not possess the space for a specially designed coffee shop.

Members of the house staff (interns and residents) and dietary department employees do not purchase meal ticket books. They are not charged for food. The house staff men are paid small stipends, and their long and irregular hours of duty cannot be compared with those of regular hospital employees or even with those of x-ray and laboratory technical students. Their uniforms constitute their pass through the line. We have practically eliminated all of the usual interns' gripes about food by letting them pick and choose as much as they wish from a considerable variety!

Dietary employees are usually in the lowest hospital income brackets. They have many opportunities to eat as they work or to speculate from floor kitchens or even from patients' trays. It was agreed by our special committee that this group should not be charged for food during a trial period. Their salaries were not increased by 40 cents per meal when the pay cafeteria opened. The problem and the method of solving it were carefully explained to all other employees. The situation was accepted from the beginning without grumbling or criticism and the dietary employees continue to receive meals without charge.

Private duty nurses and medical staff physicians are not eligible to purchase meal ticket books at a discount. We no longer sustain a loss

from feeding them. Several physicians who had been absorbing free meals for years complained about the new system, but not for long, and we recall one who shamefacedly admitted, a few weeks after he began to pay cash, that it was about time he and his colleagues were being charged. The number of meals eaten by physicians at the hospital has actually increased from a dozen or so to 30 or more each day, and they are happy to be permitted to pay for the food they consume. In addition, they frequent the snack bar after morning rounds or surgery for a welcome cup of coffee.

Employees may bring their own lunches and eat them in the cafeteria. Few of them actually do.

We can summarize the experiences of operation of a pay cafeteria-snack bar for more than two years as follows:

1. Employees prefer to receive cash and buy their food.
2. The variety of foods made possible by the addition of à la carte dishes makes a popular bill of fare.
3. Deficits anticipated from absorption of overhead costs, employment of at least one more person (a cashier), and employees not buying back the food for which their salaries were increased were sharply curtailed and finally completely eliminated. This resulted from reduction of food wastes, control of meals authorized, elimination of free meals to attending physicians and others, and extension of cafeteria hours to give between-meals snack bar service.
4. Visitors and others who have business or interests at the hospital know they are welcome to patronize the cafeteria or snack bar. This is positive public relations.

All in Favor of INCLUSIVE RATES

DAVID WACHS

Superintendent, Beth Israel Hospital, Passaic, N.J.

ON Nov. 1, 1947, Beth Israel Hospital, Passaic, N.J., adopted an inclusive rate charge system as an attempt to improve its services and to better relations with its patients. The reasons advanced for its adoption were:

1. To remove the catastrophic financial impact occasioned by unforeseen complications and acute and involved illness.

2. To remove the inhibitions of the attending physician that prevent him from ordering as complete a work-up as necessary because of the additional costs to the patient.

3. To help the patient budget for his hospitalization by being able to state the total charge in advance, the only variable being the number of days of hospitalization.

MONTHS OF PREPARATION

Before the inclusive rate system could be introduced, months of preparation were involved—in thorough discussion with the medical staff to gain its understanding, approval and cooperation; in developing tables based upon our actual previous charges to patients, correlating total charges against the number of days' stay using the existing schedule of room charge plus extras.

During the study of these data and discussion of the program a number of questions were raised, questions that always come up when "inclusive rate" is mentioned. "Won't the doctors take advantage of this and indiscriminately order excessive x-ray and laboratory services, thereby tremendously increasing hospital costs?" "What of the patient who does not need all the services, and necessarily pays for the one who requires greater

care?" "Why shouldn't the patient pay for what he gets?" To answer these questions, it was necessary to examine the basis of the existing charge system, room rate plus extras, and as we examined and studied this we noticed greater and greater contradictions.

1. We seemed to be opposed to inclusive rates for private admissions, but nevertheless admitted ward patients on an inclusive rate, entered into contractual relations with Blue Cross plans based upon an inclusive rate payment plan that allows all necessary x-ray and laboratory examinations, and accepted and wanted payment from government on a reimbursable cost formula which was, by its nature, averaged and inclusive. If in these instances an inclusive rate was not only acceptable but actually wanted, why discriminate against the other patients?

2. We discussed free choice on the part of the patient. But outside of free choice as to the type of room, and frequently not even then, how much free choice does a patient have? Does he have free choice if his doctor orders penicillin, streptomycin, intravenous fluids, oxygen therapy, transfusions? Does he have free choice if his doctor requires sedimentation rates, prothrombin time determinations, blood sugar, blood counts, or other tests? The maternity patient requiring a pelvimetry, the fracture case requiring diagnostic x-rays, the urological patient requiring cystoscopy or pyelography—do they have free choice? No; free choice is not something that a patient has. What he requires he must have, regardless of whether he can budget for it or not.

3. We discussed the unfairness of

having the patient who receives relatively little pay as much as the patient who requires extensive treatment. Is the room plus extra charge any better? Do room rate charges cover the cost of room, meals and nursing care? Do charges for "extras" or ancillary services have any relation to their costs? Is it fair to make the patient unfortunate enough to require ancillary services pay far beyond their cost in order to balance the loss on the daily room rate? That is what room rate plus extras accomplishes. Can the inclusive rate be any worse?

4. Then we were worried that the medical staff would order excessive examinations. By excessive do we mean unnecessary? In a hospital where case records are reviewed professionally, doctors will not expose themselves to ridicule by simply ordering for the sake of ordering. Then do we perhaps mean not unnecessary but rather additional examinations because there will be no additional charge? Frankly, if these additional examinations are necessary, and if an inclusive rate makes them possible—makes possible better medical care as a result—is this a criticism?

OVER-ALL COSTS SMALL

5. Would our actual costs for providing these additional laboratory, x-ray and other services not greatly affect our per capita cost? Basically, our fixed charges, our nursing costs, dietary costs, laundry costs would remain approximately the same. In fact, even the personnel services in the laboratory and x-ray departments should not increase. The only increases would be in the cost of supplies, namely, additional x-ray films, laboratory reagents, and other laboratory supplies. Over-all these additional costs would amount to relatively little. Insofar as the loss of income for these services was concerned, this is only "paper income" inasmuch as previously many of these examinations would not have been ordered, and therefore there would not be a decrease in income, but rather a decrease in potential income which is problematic.

After reviewing and discussing all the data, all the criticisms, pro and con, and arriving at the conclusions as outlined, a joint meeting of the medical staff and board of trustees recommended the adoption of an inclusive rate charge system, and the board of trustees authorized its inception.

Statistical studies of actual patient

charges indicated that shorter stay patients, in their over-all payments, had a greater per capita charge than did longer stay patients, and that we were almost able to plot a straight line graph for hospitalization from one to eight days against a per capita return. We also had available our cost data for 1946 and the first six months of 1947. We projected possible cost increases for 1948 both because of increasing costs, and also to anticipate an increased service demand with inclusive rate, and thereby determined a possible per capita cost for 1948 of \$14 a day. Knowing that our average patient stay was between seven and eight days, we determined that a patient occupying a three-bed room for eight days should pay an amount equal to our cost, or \$112; a patient in a two-bed room should pay a surplus of \$1 per day, and in a private room, a surplus of \$3 per day; rates for four-bed and five-bed rooms were proportionately lower. Our rates for the first 10 days for a three-bed room are as follows:

Day	Rate	Cumulative
First day	\$20	\$ 20
Second day	18	38
Third day	16	54
Fourth day	14	68
Fifth day	12	80
Sixth day	11	91
Seventh day	11	102
Eighth day	11	113
Ninth day	10	123
Tenth day	10	133
Thereafter	\$10 per day.	

A patient stay of under eight days gave us a greater per capita return and, similarly, the longer stay patient gave us a lesser return.

After more than two years with the inclusive rate system we are convinced that we are on the right track. There are some minor criticisms, but the benefits more than overshadow these—benefits to the patient, benefits to the physician, benefits to the hospital. We can point to definite accomplishments and conclusions.

1. Ancillary services, x-ray and laboratory examinations, have increased but not to a greater extent than had been expected.

2. Our costs have not exceeded our expectations, and are below the anticipated \$14 a day, while our income from private patients has exceeded the cost of services rendered and in the over-all has provided some surplus.

3. We have greatly reduced, in fact practically eliminated, bad debts be-

cause of the ability to predetermine the patient's bill, and also because we have removed the possibility of the unforeseen additional charges resulting from the ordering of so-called "extras" which became greater than the patient's ability to pay.

4. We have stimulated an increasing number of admissions of medical

patients requiring more than merely therapeutic surgery.

5. We have engendered in the medical staff an awareness of the hospital's facilities and a desire to utilize them fully.

6. We have attempted to give to the community a broader program for better medical care.

Keep an Eye on the Operating Room

THE articles that have been written and the lectures that have been administered on the subject of waste would probably fill a fair sized library. However, it is a recurring ubiquitous problem which is particularly challenging in these days of expensive hospital (and all other) care. The chief items of waste are: (1) money, (2) time, (3) supplies and (4) energy.

Assuming that the hospital is efficiently managed and that the board, the director, the purchasing executive and the department heads are on their toes, there will not be any waste as far as money is concerned. If the contrary should prove to be true the remedy would be simple.

As regards waste of time, most of us know that in any large institution there are bound to be a few easy-going individuals to whom we might refer as "drifters." These employees delight in wasting not only their own time but also the time of other conscientious workers. Waste of time can prove to be expensive but here again the remedy is a simple one.

The most prevalent type of waste is abuse, misuse and downright theft of supplies. When we consider that we must replace items which employees walk off with, theft falls into the waste category. Eternal vigilance and an occasional police court sentence will help this situation.

Waste of energy is a long story all by itself. Its control is a severe test of administrative efficiency. Waste of this kind cuts across all departments. In some respects it is a relative as well as an absolute organization fault. The therapeutic trick in its control lies in efficient supervision.

Medical and surgical supplies are high on the priority waste list in most hospitals. At this point I am reminded of an embarrassing incident which recently occurred to one of my col-

leagues. A staff physician came into his office and questioned a patient's bill. My friend agreed with the physician that the bill was high and at the same time he pointed out that in 1938 the hospital was spending \$30,000 per month whereas today the expenses are \$105,000 per month.

The physician was impressed by these figures and as he was leaving he said, "What about waste?" The administrator assured him that there was no waste in his hospital. He made rounds daily. The kitchen garbage was sold to a local farmer, the boiler room ashes were carted away and paid for, the waste fats from the kitchen were sold to a soap manufacturer, scrap metals were sold to a junk dealer, expensive steam was not being wasted, but put to work.

At this the physician had to leave but before doing so he said, "Keep your eye on the operating room crew." My colleague, like most of us, depended on his efficient director of nurses and competent operating room supervisor to safeguard supplies. You can readily imagine his surprise therefore when in 30 minutes he discovered the following:

- (1) A surgeon receiving a 3 ounce vial of cocaine for a procedure which requires about two drams; (2) a cup of merthiolate being given when only an applicator was required; (3) a surgeon using a 27 inch suture instead of a much smaller one, and (4) a nurse wasting expensive disinfecting solution by using a wide tray full of solution when a narrow boat would have served the purpose.

All of us should profit by this administrator's experience. Hospital costs are increasing and if we are to escape criticism we must be on the alert at all times to avoid waste of hard earned charitable funds.—JOHN F. CRANE, director, Paterson General Hospital, Paterson, N.J.



John H. Olsen of New York, Dr. Frank Bradley, St. Louis, Lee S. Lanpher, Cleveland, and Lawrence Payne, Baylor University Hospital, Texas, registering at the opening of the Protestant conference.



At the speakers' table during the Protestant conference were, seated, John G. Dudley of Houston, who was named first vice president of the Association, and Dr. Seward Hiltner, at the microphone.

Protestant Organizations Hold Annual Conferences in Chicago

CHICAGO. — Meeting for the first time apart from the American Hospital Association's annual convention, the American Protestant Hospital Association brought more than 1000 hospital administrators, trustees, staff members and departmental executives together here last month. Preceding the two-day conference, Protestant groups representing several different denominations met to discuss their own special problems.

At the conclusion of the meeting Leo Lyons, director of St. Luke's Hospital here, was named president-elect of the A.P.H.A. Dr. Malcolm T. MacEachern, director emeritus of the American College of Surgeons, became president, succeeding Rev. L. B. Benson of Minneapolis.

The association adopted a resolution approving and urging strong support of Blue Cross and Blue Shield plans and expressing opposition to the compulsory health insurance program proposed by the federal government. The association's resolution also urged hospitals and hos-

pital groups to make every effort to get recognition from local and state governments of the need for full cost payments for care of indigent patients.

In one of the principal talks presented at the A.P.H.A. meeting, Dr. Frank R. Bradley of St. Louis referred to federal subsidy as a form of "found wealth."



Leo Lyons



Dr. MacEachern

The voluntary hospital system parallels the profit motive in the capitalistic business economy, Dr. Bradley said, and is therefore "as American as pork and
(Continued on Page 146.)

Methodist Conference

CHICAGO. — Increased support by the Methodist Church in America for church hospitals and homes in Western Europe was urged by Karl P. Meister, executive secretary of the Methodist Board of Hospitals and Homes, at the opening meeting of the annual convention of the National Association of Methodist Hospitals and Homes here last month. Mr. Meister described his visit last fall to Methodist institutions throughout the Scandinavian countries, Germany, Italy, Switzerland and England.

"Despite tensions, Europe is rebuilding spiritually and materially with sacrifice and devotion," Dr. Meister said, "always mindful of gifts from America. In the face of trends toward state welfare programs, the Church must be awakened to the opportunity and the need for Christ's healing ministry in Europe. If the free churches are to continue in institutional service they must struggle against advancing national welfare programs."

Mrs. Josie M. Roberts, director of the
(Continued on Page 148.)

Left to right: Rev. Vernon Serenius, Omaha; Kenneth Woltz, Astoria, Ore.; F. A. Hanson, Des Moines, Iowa; Arthur Calvin, St. Paul, Minn., and L. M. Conley, also of St. Paul, listen attentively.

Left to right: Hillis Youngdahle, Moline, Ill.; Rev. Granger Westberg, Chicago; Rev. John Bilinsky, Boston; Hal Perrin, Omaha; Rev. William Sodt, Milwaukee; (standing) Rev. Armour Evans, Wichita, Kan.



The Social Aspects of CHRONIC ILLNESS

MRS. SAHRA S. RAPP

Director, Department of Social Work
Boston City Hospital, Boston

ONE important rôle of the medical social worker is that of interpreter. Within the hospital where she practices, she interprets the doctor's medical recommendations and the hospital to the patient and patient group, the patient and his social situation to the doctor, to other hospital personnel and to the hospital administration. Outside, to the community, she interprets the patient, his needs and the hospital.

PROBLEM IS GROWING

This rôle is especially important in relation to chronic illness because of the extent of the problem, for, while chronic disease may and does strike at any age, we do know that it is more likely to come with advancing years. We know, too, that with the progress of medical science, the life-span has been increased so that our population is now comprised of more aging and aged whose numbers should increase with time. Thus, the hospital that cares for the acutely ill now finds more of its beds allotted to the chronically ill, side by side with the acutely ill. This creates many problems. Since the hospital in its present setup is not equipped to care for these patients indefinitely, reorganization and new programs need careful consideration. This is not a concern of one local community, or of one state or nation, but of all nations, and more interest must be aroused not only among professional groups dealing with health and welfare, but also among other professional and lay groups, since all of society is involved.

It takes time for a community to evolve a setup that is ideal and workable for it, for just as patients need to be individualized, so do communities differ and each has to meet its needs in its own way. Meanwhile how does the medical social worker function within the existing framework and what are her findings? How should

she interpret and translate these findings into social action?

I should like to discuss these questions in the light of my experience in a large, busy municipal hospital dedicated to the care of the indigent sick. A municipal hospital cannot turn anyone away who is acutely ill, and after a patient is admitted, if he is found to have a chronic illness, he must be cared for until a suitable plan can be made. In order to act as interpreter to the patient and patient group, the worker must be skilled in her knowledge of the interrelationship of medical and social factors, of personality and behavior. In order to help the patient accept a plan of care, she must be able to give him sympathetic understanding and identify herself objectively with him. To complete the plan, she must not only have a knowledge of community resources, but should also have an awareness of inadequacies and be constantly alert to devising ways and means for correcting them and for establishing new programs.

While adequate plans are not easy to make even for the wealthy, since there are limited facilities, it requires even more ingenuity to plan for the indigent. If the patient coming to the municipal hospital requiring careful medical and nursing supervision has a family, usually his income is inadequate, his home, with the present housing situation, crowded living conditions and resultant emotional tension, cannot offer opportunity for proper care, nor does the limited budget permit the additional financial strain of care outside of the home even for a temporary period following an acute exacerbation of the patient's illness. If the patient has been the breadwinner living on a marginal income, his illness can easily be aggravated by his worry of conditions in the home, which the worker must try to alleviate in order that the

patient may benefit from medical treatment.

The following situations are examples:

Mr. S., aged 54, was admitted to the hospital because of pneumonia which soon cleared. His chief difficulty was a cardiac condition necessitating two months' hospitalization. A review of his social situation revealed that he was the father of two daughters, age 10 and 17, respectively. The latter had completed high school and was attending an evening business school. Her ambition was to become an accountant. Her "take home" pay was \$18 per week; she contributed \$8 to the maintenance of the household. Although, prior to his hospitalization, the patient had been earning a fairly good salary as a laborer, for many years he had worked irregularly at a low salary so that the family's small savings were soon exhausted. After three weeks' hospitalization, the doctor recommended that the patient do no work for at least three more months. The worker arranged for the family to receive Aid to Dependent Children for patient's wife and younger daughter. When the patient was ready for discharge, the doctor advised limited activity for four to five weeks, a restricted diet which was especially important because the patient was obese, and continued follow-up care in the outpatient department.

PRIVATE FUNDS AVAILABLE

The patient's home could not offer proper convalescence because it was inadequately heated and his wife was tired as a result of the financial and emotional strain caused by patient's illness. Private relief funds made possible convalescence in a nursing home and transportation to and from clinic. When patient returned home, aid was increased to include his support. Two and one-half months after his dis-

Revised copy of paper presented at the Massachusetts Public Health Conference and New England Health Institute, Amherst, Mass., June 17, 1948, in panel discussion "Chronic Illness, a Challenge to Public Health."

charge, patient was told that he might try to do light work. Fortunately, he had an understanding employer who arranged proper work for him. Later his wife needed medical attention and the worker was able to help her. The worker maintained an active interest in this family for seven months until conditions had improved.

Mr. A., aged 62, was admitted with coronary thrombosis. A social review revealed that his attack had occurred following an argument with his family about finances. The patient, a former factory worker, had been unable to work for some time previous to his hospitalization and had been unhappy about his financial dependence upon his family. His family had not been too understanding. His condition was further aggravated by concern for his wife, a diabetic, who had recently had a partial amputation and was not receiving regular medical supervision. She had not yet learned to use her crutches; as she was unable to assume her household responsibilities, her children had to pay for housekeeping services which they could ill afford. A young daughter, who required the supervision of a protective agency because of her delinquency, caused the family much anxiety. Because the family feared the authority of the agency, they unwisely tried to hide her escapades.

WORKED WITH FAMILY

Obviously this home could not give the patient the physical and emotional rest which he required. Therefore, convalescence was provided from private relief funds. In order to help this patient, it was necessary to work intensively with him, his wife, and other members of the family to interpret the interrelationship of the social and emotional factors and patient's illness. The worker tried hard to strengthen family relationships, to arrange medical supervision for the wife, to give advice and assistance regarding an artificial limb and to bring about better understanding between the protective agency and the family.

After one month's convalescence, the patient returned home and managed fairly well for three weeks when he learned that his daughter was illegitimately pregnant. This knowledge precipitated another attack, necessitating readmission to the hospital followed by another period of convalescence. The family now felt that all these events might have been pre-

vented and realized the folly of their attitude toward the protective agency through which care for the daughter finally had to be arranged and plans for her future made.

This situation had been followed actively for a period of six months. The patient was still under medical supervision but not yet able to work. Home conditions had improved somewhat with the daughter out of the home temporarily, with the wife under medical supervision, and with the family's better understanding of the effect of emotion on patient's illness. At this time, the patient decided to transfer his medical care to a clinic nearer his home. No doubt further casework services will be necessary when the daughter returns.

Unfortunately the chronically ill patient usually presents a less dramatic and exciting picture than does the acute case, and the young intern who is extremely busy and eagerly learning his physical medicine has not yet willingly come to accept chronic disease with its attendant social problems as an integral part of his responsibility as a physician. Once he has made his diagnosis and prescribed the medical treatment, he would like to relegate the chronic elsewhere, but alas he cannot do so!

In an article entitled "Medicine Is Not All—Those Patients Are Still People," Dr. William Seymour discusses the doctor's attitude in relation to a patient, who had supported his family adequately until his hospitalization for coronary thrombosis. He comments: . . . "Considerable interest was evinced by the staff in the nature of the onset of his illness which was unusual and in the changes in his electrocardiogram.

"Once the diagnosis was established, however, he rapidly became 'that coronary in bed 3,' and was given the usual treatment, that is, bed rest. The patient had been reassured that the staff knew what they were doing with him and that they 'understood his case.' So they did—medically—but what they did not know was that the patient was wondering how he could meet the next payment on his mortgage, and on his insurance, and his grocery bills, and what his family would do, and what his own future might be.

"The interns' assurance that he would be all right was only of minor importance to him—his family and his actual problem of living in the future was his chief concern. It was not until

the social service worker spent a little time with him at the request of the staff that a means was provided for solving his problems, and his heart rate slowed perceptibly without any further digitalis. Solution of his social problem here was quite important medically; to the patient it was paramount . . . it is in hospitals treating the indigent and the semi-indigent that the use of social service intelligently applied is of utmost importance as a therapeutic measure. Hospitals and related institutions, founded for the most human and humane purposes, tend to develop machine-like qualities which inveigh against their very purpose.

"Even the physician who is most solicitous of the patient's welfare finds that the pressure of work and time compels him to devote himself largely to the seriously ill patient and, at that, largely to the illness rather than to the patient."*

RELUCTANT TO CHANGE

If the medical recommendations necessitate a radical change in the patient's way of life, such as chronic hospitalization, it takes time for the patient's acceptance of such a plan and for its completion. It is not easy for any of us to give up the known for the unknown without careful deliberation. Furthermore, chronic hospitals are usually some distance from home and even though "home" may be only a furnished room, the patient gives it up reluctantly. Recently, a 54 year old patient who had had frequent readmissions to the hospital was urged to consider chronic hospitalization. Although he was living in a furnished room, eking out an existence on public relief, had few interests and few friends, he was adamant in his refusal. He said forlornly, "If I go—it will be the end—my friends will forget me and I will never be able to come back."

When a patient does finally agree to accept chronic hospitalization he must wait for a bed as there are long waiting lists.

If the patient's need can be adequately met in a nursing home, there are other problems to be considered. Nursing home care is available only to the patient who can pay for it. In my community, if a patient is under 65, and dependent upon public relief, his grant is not sufficient to permit placement in a nursing home. In this state,

*Seymour, William: *Medicine Is Not All—Those Patients Are Still People*, *Hosp.* 18:64 (December) 1944.

if a patient is 65 or over and is not a citizen, he cannot receive old-age assistance. He may be receiving old-age and survivor's insurance, but the benefits under this program are not yet usually enough to finance placement. A citizen who is otherwise eligible can have his benefits supplemented by old-age assistance. If the non-citizen of this age group has not worked in covered employment, he can receive dependent aid only and is therefore in the same predicament as the patient under 65. When a patient is receiving old-age assistance, a nursing home can be provided, but not without difficulties, because the grant is not high and there are limited facilities.

The fact that all these problems delay the patient's discharge is irritating to the intern, to the nursing staff, and to the hospital administration. However, the worker with vision and imagination cannot permit herself to be disheartened or frustrated for long. Instead, she is stimulated to greater effort and activity in her daily relationships within the hospital to interpret community inadequacies and to work jointly with others outside the hospital in an attempt to bring about changes to meet them.

For example, during the war, when it was extremely difficult to find nursing home vacancies, many of us felt that it would be helpful to have a central placement service, through which the community might place the convalescent and chronically ill patient requiring nursing home care. We thought, too, that such a service might help to improve standards and develop resources for special needs. It has taken much time and effort, but finally through the activity of a nursing home committee composed of medical social workers from various hospitals, a convalescent placement service was started, with a social worker as director, who keeps in close touch with the state department of public health which since September 1948 has had the responsibility for licensing these homes. For the first four months in 1947, the director placed 119 patients in nursing homes; in the same four months of 1948, the number had increased to 235, almost double that of the previous year. Needless to say, this service is a great time-saver to many of us in Boston and helps to make hospital beds more quickly available. The nursing home committee has also tried to effect a closer working relationship with nursing home proprietors and is now trying

to promote interest in handicrafts for patients in nursing homes. There is still much to be done to improve life in the nursing home and several types of homes are necessary.

While the medical social worker's activity with the chronically ill has been largely palliative, actually she is looking ahead to the future and is thinking in terms of prevention. Thus, we find her teaching the social component in medicine to medical students, interns, and student nurses to give them a greater awareness of their responsibility to society. Through participation in various committees and her professional organizations, she is trying to be more vocal in social legislation.

There is much to be done in this field. We say in a democratic society that we believe in the worth and dignity of the individual, that he has a right to independence and self-maintenance, yet when he is ill and without funds, we subject him to the indignities of relief. There is a great need for temporary and permanent contributory disability insurance and medical care for all. Social Security coverage should be extended to those now excluded. Industry should make necessary readjust-

ments to enable an individual to be employed as long as possible, for a person properly occupied is usually a happy person, and a happy person, a healthy one. Old-age and survivor's insurance benefits should be increased. I believe that the retired individual who is able would be encouraged to work part time if he were permitted to earn a higher maximum than \$14.99 per month in covered employment without sacrificing his benefits. It is gratifying to note that Congress is now considering a bill which would increase this figure to \$40 per month in covered employment without loss of benefits. Paradoxically enough, the retired person who does not wish to be idle, may be able to obtain work in employment not covered by social security without being disqualified for benefits regardless of the amount of earnings. More thoughtful planning for leisure time activities is necessary. Much more needs to be done about housing which is fundamental to good health. Obviously, in order to be truly effective and to meet her responsibility to society, the medical social worker must combine her efforts with many lay and professional groups for the betterment of all.

The Health of Nurses

The nurses' health as a factor in the shortage of nurses has been appraised by Dr. Donald Court and his findings have been published in an article in the *Lancet*, November 12, entitled "The Health of Nurses in Hospitals."

This is a detailed survey of the health of 300 nurses during three years (1943-45) in an urban hospital near London which inquires as to the part sickness plays in the problem of nurse wastage.

It is highly probable, the author states, that the health of hospital nurses is less satisfactory than the health of women in other professions and that this excessive illness is mainly due to respiratory infection, skin sepsis, infective diarrhea, infectious fevers, and tuberculosis.

Of the 300 nurses, 6 per cent developed tuberculosis during the survey, with the loss of 3000 working days.

Ill health was found to play a large and unsuspected part in wastage; 17 per cent of those leaving the hospital and 25 per cent of those leaving the profession (at least temporarily) did so for this reason.

In the light of this and other surveys the principles concerned in the reasonable care of the hospital nurses' health are considered and a number of practices are proposed which could be carried out readily in most hospitals.

1. Thorough initial physical examination.
2. Further routine examinations, particularly at the end of the three months' probationary period.
3. Annual chest films and hemoglobin estimations.
4. Immunization.
5. Mantoux—negative nurses should not be permitted to work on tuberculosis wards.
6. Generous and attractive sick ward accommodations with the freedom to report sick without fear of rebuke.
7. An active program of health education.

The author closes with the hope that the facts revealed will lead to the more effective care of nurses' health and greater efficiency in the nursing services.—MALCOLM SMITH, administrative resident, Montefiore Hospital, New York City.

How **NURSE ASSISTANTS** learn their trade in Texas

RUTH SCHWARZWALDER, R.N.

Director, Nurse Assistant School, University of Houston, Houston, Tex.

NURSING service for the future development of the Texas Medical Center will be provided in part by the University of Houston Nurse Assistant School, whose training program was created in February 1948 to relieve a shortage of nursing service in Southeast Texas.

The future needs of the Texas Medical Center were determined from a survey made in 1946 and 1947 at the request of medical center authorities by Hamilton and Associates of Minneapolis. Lucile Petry, assistant surgeon general of the Public Health Service, conducted the survey on nursing needs.

As a result of this survey the University of Houston, in keeping with its policy as a service institution, established the nurse assistant school as a part of its vocational division.

A nurse assistant is defined by the university, the cooperating hospitals and Houston health agencies as a person trained to care for subacute, chronic and convalescent patients in their homes or in institutions, and is taught to work as an effective member of a nursing team made up of professional nurses, student nurses, nurse's aides, maids and others. She works under the direction of a registered nurse or licensed physician.

Partial financing of the nurse assistant school is furnished by junior college aid and appropriations from the Smith-Hughes Act allocated through the Texas State Department of Vocational

Education, Trade and Industrial Division.

Training begins with a three-month preclinical period, with instruction in theory, demonstration and practice of the basic nursing procedures. This instruction is four hours daily or a total of 140 hours of instruction during this period; 48 hours of this time is spent in special instruction by a qualified home economics instructor. Classes in the preclinical period are held in the nurses' building of Hermann Hospital. This building is equipped with class laboratories, library, gymnasium, lounges and dormitory rooms.

FOUR AFFILIATED HOSPITALS

The clinical period which follows consists of nine months of duty in one of the four affiliating hospitals: Jefferson Davis, Hermann, Memorial or Methodist. Ward conferences and group instruction are required for a minimum of one hour daily. Instruction and supervision are done by a clinical instructor.

The University of Houston provides the nursing arts and clinical instructors and reserves the right to adjust and

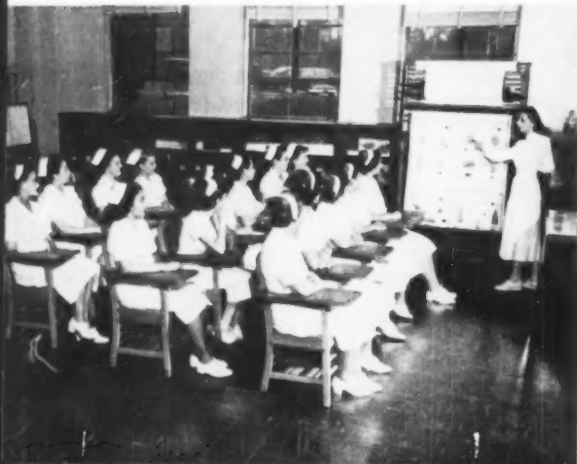
change the program from time to time with the approval of the hospital management.

Students are allocated to the cooperating hospitals on the basis of their annual requests, or proportionately in case the requests exceed the supply of recruits. The university prefers to send students to hospitals in groups of 20; the desirable number of students for each clinical instructor is 20 or less. Special consideration is given to providing additional supervision during the student's orientation period in clinical instruction.

Class group instruction is given for one hour a day, five days a week during this period. Instructors keep records of this instruction and report to the director of the nurse assistants' program. Each group has at least one additional meeting per week for general orientation instruction in the operation and services of the hospital. Hospital administrative and supervisory employees assist in giving these lectures.

During the clinical period, students are on duty under supervision during the daytime hours with the exception of two weeks' evening duty and two weeks' night duty at the end of the clinical period. Assignments are rotated periodically in order to give the student experience in the various departments, i.e. medical, surgical, obstetrics, pediatrics, diet kitchen. Absenteeism is made up in the department

Left: In the preclinical period, students receive 140 hours of instruction in theory, demonstration and practice. Right: Learning how to make a bed properly is part of the training.





where time was missed. A 44 hour work week is required for students in the clinical period.

Clinical instruction is followed by a six months' internship in an approved hospital under the supervision of a registered nurse or licensed physician. During this period nurse assistants are considered employees of the hospital and follow personnel policies of the hospital. Upon successful completion of this internship, the student is awarded the graduate certificate and emblem.

The program is financed with state and federal funds. The cost to the student is a fee of \$30 for the first three months and \$30 for the next nine months. An additional charge of \$7 per month for each student is paid by the hospital during the clinical instruction period.

Students provide their own meals. Dormitory rooms are available to them in the nurses' building of Hermann Hospital during the preclinical period at a cost of \$5 per week. Laundry of uniforms commensurate with the number done for graduate nurses is provided by the hospital.

All students are required to take Blue Cross insurance.

Holidays observed by the hospital are granted, with a two-week vacation allowed upon completion of the clinical instruction period.

To be eligible for entrance students must be between 17 and 45 years old and must have completed two years of high school. They must be in good physical condition as determined by the entrance physical examination and completion of psychological tests and personal interviews.

The objectives of the nurse assistant school are to develop in each student:

Left: Study of home economics is included in preclinical work. Center: Nurse assistants work with R.N.'s during clinical period. Right: An assistant attends a convalescent patient.

1. The ability and desire to engage in sound health practices for herself and her patient.

2. A sufficient knowledge of medical terminology and common diseases for exercising judgments required of a nurse assistant.

3. The ability to work harmoniously with patients, patients' relatives and professional personnel.

4. A sense of responsibility toward the faithful performance of her duties.

5. Skill in: (a) performing nursing procedures; (b) planning, preparing and serving attractive and well balanced meals for patients; (c) planning and assisting with household duties necessary for the comfort and welfare of the patients; (d) maintaining a comfortable and healthful environment for the patient in the home or the hospital; (e) contributing services as a nurse assistant to the community for the welfare of its people.

The uniform worn by the nurse assistant is white and short-sleeved, supplemented by a red cap with white band, beige hose, white shoes and a red and white nurse assistant emblem on the left sleeve.

The course of study was recommended by the working committee consisting of Daisy Moore, director of nurses, Memorial Hospital; Josephine Post, director of the University of Houston College of Nursing; Marie Luppold, director of nurses, Methodist Hospital; Elizabeth Nichols, director

of nurses, Jefferson Davis Hospital; Lauretta Mae Miller, Houston Independent School District, and Willie Sass, president of the Houston-Galveston League of Nursing Education. The curriculum and program were decided on after a detailed study of "The Job Analysis of the Practical Nurse Occupation," completed under the auspices of the United States Office of Education.

After a period of two years' experimentation in the field of practical nursing, our plans call for expansion of our program. We have found that the National Association for Practical Nurse Education is invaluable for consultation in setting up new programs and expanding those in progress.

As a result of the combined efforts of 250 representatives from the state of Texas, the workshop on Practical Nurse Education held at the Veterans Administration Hospital in Houston from February 13 to 17, recommendations were made to extend the preclinical period to four months—six hours per day classroom theory and practice laboratories and to delete the six months' internship period.

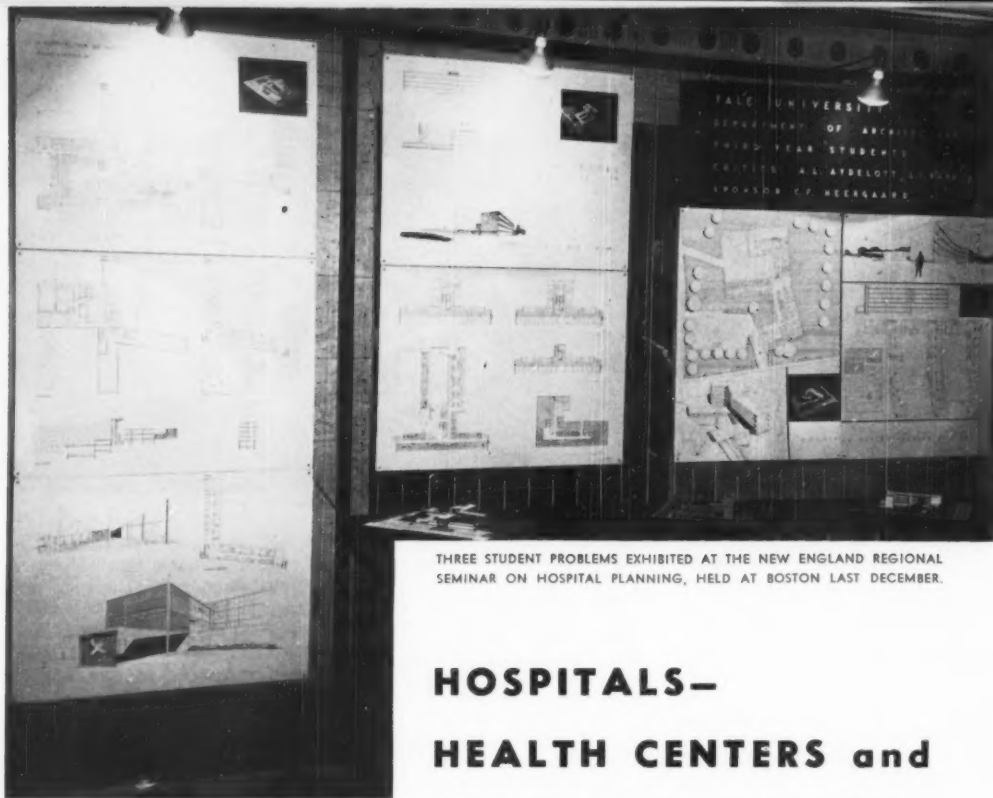
Final recommendations included three main points:

1. Consultation services from N.A.P.N.E.

2. A preaffiliation agreement with hospitals.

3. A good orientation program (see N.A.P.N.E. booklet, "How to Fit the Practical Nurse Into Your Organization") is most important for all personnel.

We find that an approved program for practical nurse education does not cost any more than a program that is not approved, and is more efficient and economical.



THREE STUDENT PROBLEMS EXHIBITED AT THE NEW ENGLAND REGIONAL SEMINAR ON HOSPITAL PLANNING, HELD AT BOSTON LAST DECEMBER.

HOSPITALS— HEALTH CENTERS and GROUP MEDICAL PRACTICE

MILTON I. ROEMER, M.D., M.P.H.

Assistant Professor of Public Health, Yale University

THE architectural plans presented here give expression to several movements in the organized provision of health service which had their origins many centuries ago. The conception of these plans embodies a meeting of three great historic streams—hospitals, public health, and medical specialization—each arising separately and all coming together today because of far-flung social influences.

The health center is of more recent vintage than the hospital. It is a relatively modern physical expression of the public health movement, or man's effort to control or prevent disease through community action. Elements of public hygiene were practiced by the ancient Hebrews and later the Romans, but a systematic responsibility of government for the preservation of health—largely through environmental controls—was not clearly recognized until the 18th century.¹

In America, sporadic efforts were made to control epidemics in Colonial times, but full-time professional services in sanitation and communicable disease control were not launched until about the period of the Civil War. The public health agency was a weak

sister in the family of local and state government, however, for many decades. Not until after World War I did the health department begin to leave the basement of the courthouse for a separate structure of its own: a health center. The conception of the function of the health center is still quite elastic in the United States, ranging from a place for the health department alone to the very broad scope of a combined hospital-public health-physician center contemplated in the architectural plans presented here.²

The group medical practice clinic probably derives its conception from the polyclinic of the large public hospitals in European cities. As a form of private medical practice, however, it is a uniquely American phenomenon, resulting from the high development of specialization in American medicine. Specialization in some form is found as far back as the Egyptian world, but its development to a major trend in the "regular" medical profes-

sion did not reach maturity until about the present century.³ Aside from the pioneer ventures of the Mayo brothers, private group clinics began to be a significant pattern in American medical practice after World War I. They have brought together teams of medical specialists and attempted to solve the problems created for the patient by the division of the human body among a score of different technical disciplines.⁴

While these three forms of social organization for health service—the hospital, the health center, and the group practice clinic—have had these quite separate origins, developments in the applications of science have increasingly given them common functions and interests. A few examples will illustrate this. The hospital, initially a place simply for the bed care of the sick, has come increasingly to be a professional center for the diagnosis of all serious illness (as well as its treatment), for the professional

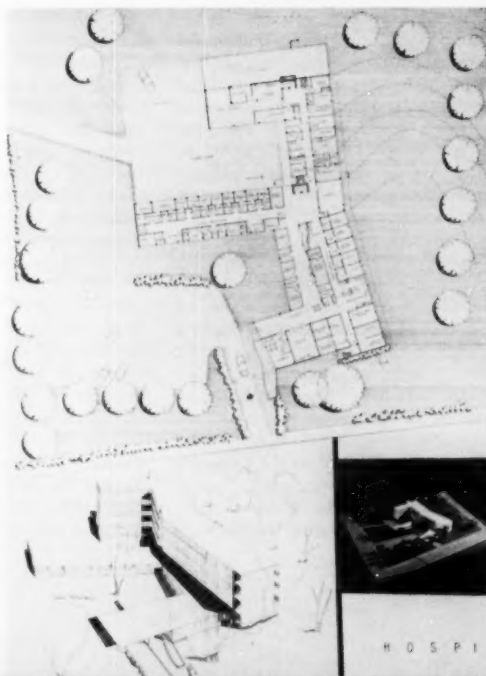
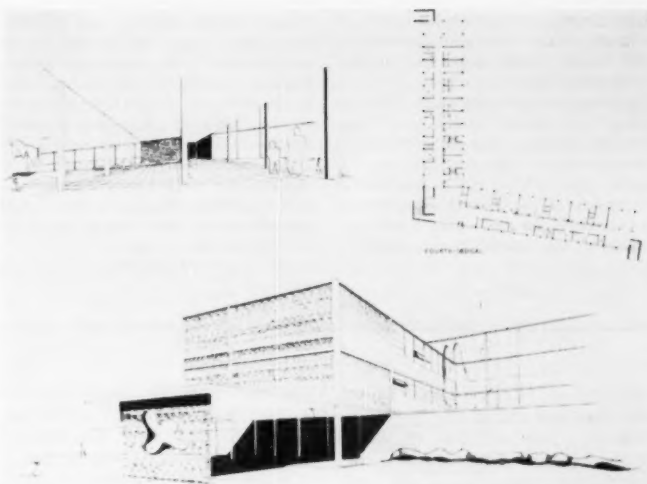
education of physicians and other personnel, for the provision of ambulatory services through clinics, and even for the prevention of disease. Thus many hospitals operate laboratories and x-ray departments that serve all persons, not solely the bed patients; they maintain clinics for prenatal care, for children's diseases, for diabetes, and for other purposes; they perform, as preventive measures for all their patients, routine blood tests for syphilis and chest x-rays to detect tuberculosis.

Health departments, on the other hand, are no longer concerned solely with environmental sanitation. In health centers many personal health services are rendered, therapeutic as well as preventive. There are clinics for the diagnosis and treatment of venereal disease, for the preventive care of infants and expectant mothers, for immunizations, for dental care of children, for the detection of tuberculosis or cancer or rheumatic fever. Laboratories are maintained for sanitation tests and for the clinical pathological diagnosis of certain diseases. Health education is offered on the health problems of all age groups.

Group medical practice includes the services of physicians and others who are needed in the staffing of all types of community health programs. Physicians today seldom confine their activities entirely to the care of private patients, but render services in hospital and public health clinics of various kinds. The x-ray, laboratory, physical therapy, and other facilities of the hospital, moreover, render services needed by the private ambulatory patients of the medical group. A family's medical records, maintained in the hospital or health department, may be of great assistance to the physician treating a patient in the group medical clinic.

It is clear, then, that the gradually broadening rôle of all three forms—the hospital, health department, and group medical clinic—has created a situation today in which coordination of their programs becomes obviously desirable. This has been recognized by

The problem set before the students was to plan a new hospital and health center to replace an existing hospital in an industrial town of 25,000 inhabitants and to include within its zone two smaller towns. Three of the plans submitted were selected by the jury for exhibit at the New England Regional Seminar on Hospital Planning in Boston last December. These plans are shown on this page. The designers were: Top, Chia-Yi Jen; center, William Metcalf, and bottom, Herbert Shalat, all students in the department of architecture at Yale University.



THE APPROACH TO THE PROBLEM

ELFORD KING

Student, Department of Architecture, Yale University

OUR society of today lacks a sufficient number of qualified men to design well integrated hospitals abreast with our ever-increasing knowledge of advanced medical technics. This was the provocative thought behind the development of a hospital problem given to the introductory advance class of the department of architecture at Yale University. The program was sponsored by Charles F. Neergaard, New York City architect and hospital consultant.

Two thoughts were kept uppermost in the minds of both faculty and students while this program was in progress: (1) to attempt to study thoroughly and familiarize oneself with hospital functions so as to suggest and initiate advancement in hospital design as far as is possible within the students' range; (2) to explore and advance the theory of incorporating into a hospital unit a cooperative group practice unit, composed of various medical specialists, and also a public health unit.

The physical program submitted to the architectural students was to design a new hospital and health center to replace an antiquated and outgrown existing institution. This building was to be built in an industrial town of 25,000 inhabitants, and also to include within its zone two smaller towns. The structure was to be planned for major and minor surgery, complete departments in pathology, radiology and physical therapy, a public health unit and offices for a cooperative group practice. An average patient census of 60 patients per day was expected which would increase each year by approximately two patients per year for the next 15 years. A gradual expansion program in five-year periods was to be considered in providing for patient census. It was also hoped that a more intimate and human approach to hospital esthetics would be seriously considered, making the hospital a "home" for the sick.

As a student exercise, this problem was

to extend over a period of nine weeks. The first week was to be spent in absorbing research material to form a sound background for an actual design approach. From that time on, the student was to explore all possibilities of design, ultimately arriving with a scheme expressing his conception of a true and honest analysis. During this period his mental process was aided by visiting lecturers who spoke on such subjects as x-ray equipment, laundry mechanism, public health supervision, and hospital administration. Through these personal contacts with men actually working in the fields of hospital machinery and administration, the students were able to add working knowledge to their own conception of how a hospital should be controlled. Therefore, their minds were able to wander into more idealistic patterns while still being kept within the line of reason by actual personal contact with existing problems.

Two architectural critics, Alfred Aydelott

the American Hospital Association and the American Public Health Association in a joint statement of policy.⁵ Physical unity of the hospital and health department is not the only expression of such coordination, but it is surely one of the strongest. There are scores of local communities in the United States where both agencies use common facilities or equipment for certain categorical programs, and at least eight places where a hospital and health department are now housed in a single structure. Under the Hill-Burton Hospital Survey and Construction Act, at least 25 new projects throughout the nation contemplate such unified housing.⁶

Physical unity of hospitals and group practice clinics is seen in scores of communities. According to a Public Health Service survey, about 32 per cent of all bonafide group medical clinics in the nation either own their own hospital or are intimately associated with one.⁷ These combined facilities are commonest in small towns of the Midwest, and the hospital services so offered are often the only ones available in the region.

Physical unity of group practice clinics and health departments, how-

ever, has not been a reality anywhere in the United States, to my knowledge. The reason is not obscure; health centers are, virtually by definition, public institutions and medical practice, whether solo or group, is private. Public facilities are not likely to be provided for private gain. Yet in the effort to correct the shortage of rural doctors, there has been discussion of constructing health centers in rural regions, with space to be provided for groups of physicians perhaps on a rental basis. This is stipulated in the law setting up the new British National Health Service, although construction of such centers has not yet begun.

The coordinated service embodied in the architectural plans presented here, then, is in keeping with national and international trends in the organized provision of health service. The specific advantages are numerous and only the more important ones need be mentioned. The hospital, health department, and group practice team all can use common x-ray and laboratory facilities. Record space and libraries, pharmacy and physical therapy facilities can be unified. Waiting room space can be combined. Purchase and storage of equipment and supplies can

be combined. The hospital outpatient department and the specialized public health clinics can become one. The hospital dietitian can become the nutritionist in the public health program. The public health nurses can start their maternal and child health visits on the maternity service. There can be savings in laundry, utilities and garage facilities. The services of technicians, clerks, janitors, telephone operators and other staff members can be integrated in numerous ways.

With all these agencies in one place, travel time of the physicians and other personnel is saved. Patients and visitors coming to the hospital and group clinic can be reached by the educational services of the health department, and persons coming to the health department can readily be referred for medical care, as needed.

Unification of facilities means not only efficiency, savings in time and effort, but economies as well. These savings can be passed on to the consumer in lower medical fees, lower hospital rates, and even lower revenues for the support of public health services. Or else they can be enjoyed by the provision of more services per dollar spent.

Program Sponsored by

CHARLES F. NEERGAARD

Hospital Architect and Consultant,
New York City

and Louis Kahn, were circulating among the students to aid them in their analysis and to provide inspiration for a high level of design. This educational process of allowing the student complete freedom of thought provides a great opportunity for advancement in design conceptions which are not hampered with the overbearing presence of small technicalities easily solved after the broader part of the design phase has been completed.

Owing to the complexity and extensive technicalities of hospital planning, the general attitude among the students was that nine weeks provided an adequate time for research on a general level and an over-all conception of a working unit; but to study and work out the more technical aspects of a well regulated hospital would take considerably more time especially since this group had not been exposed to hospital design previously.

At the end of this nine-weeks' period, the

student problems were submitted to a jury of four—Edward Stone, Thomas Creighton, Louis Kahn and Alfred Aydelott.

It is readily understandable why no advanced or revolutionary ideas of hospital planning resulted. To achieve such goals the architect must have an expert knowledge of the working units and their individual components, which a student could not be expected at this time in his training to have.

Throughout the better problems there were several noteworthy examples of unified and well thought out planning. Excellent orientation for patients' rooms was stressed throughout. The relationships of circulation among the public health unit, group practice unit, and adjunct facilities were admirable. Simplicity and convenience of circulation made these schemes not only plausible, but well worth study. The circulation of patients and staff, especially in the surgical units, was excellent in one sub-

mitted problem. No confusion could have possibly resulted from this scheme where each related function had easy access to its neighbor. The variety of imaginative nursing room layouts was also admirable. Corridors became more than just hallways in a few cases; they became pleasant circulation paths open to the outside and filled with sunlight.

The simplicity of the plans in the better problems was good. Each unit was a definite part of the over-all composition and most circulation paths were unforced and natural. The architectural students did admirable work in making a hospital more than just spotless rooms and endless corridors; they took to their drafting boards a sense of scale and humanity which ultimately showed in the end results. Their hospitals ceased to be foreboding institutions and became pleasant areas for recovery.

Students can and do provide stimulus to their instructors and those who study their works. The search for sound logic and honest expression made this problem at Yale a worth-while contribution to the field of honest design and progressive medicine.

But more than efficiency and economy is involved. The scientific and human quality of the services of hospitals, physicians and public health agencies can be enhanced by their coordination. In a long-run historic sense, this is the era of preventive medicine.⁶ It is also the era of specialization. The best elements of both these major influences can be realized in day-to-day service to the citizen through the preventive orientation brought by the public health agency and the specialized skills of the group practice unit.

It should not be supposed that the unification of functions implied in these architectural plans could be achieved anywhere and everywhere with ease. There are many practical obstacles in local situations. Hospitals and health departments, in many instances, guard their autonomy jealously, and coordination of functions implies a give-and-take which is easier said than done.

The provision of all services in both the hospital and health department by a "closed staff" of physicians in the group clinic would obviously meet the opposition of other local physicians, nor would it necessarily be

sound socially. A prepayment plan associated with the physicians' and hospital services, as outlined in the student problem, would help to assure maintenance of the facility, but a voluntary plan of this type might suffer setbacks in bad economic times. It should be possible, however, to make suitable adjustments to all these problems, so that the proposed plan need not be considered Utopian.

There are limiting factors in the coordination of facilities presented by purely physical problems of construction and design. There are further and more serious limiting factors presented by the down-to-earth social attitudes and relationships of the public, the agencies, and the health professions in local communities.

Undoubtedly, it will be many years before the last word is said on a perfect physical expression of a united community health service, but the plans offered here make an excellent beginning. While the conceptions embodied in these plans are daring, they are really not radical. They are ahead of the times, not in their theoretical foundation, but only in their courage in being put down on blueprint paper.

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A CASE HISTORY OF JOB EVALUATION

STANLEY P. FARWELL

Chicago

IN THE spring of 1949, the administrator and the board of trustees of Provident Hospital and Training School, Chicago, were confronted with the following problems related to wage and salary administration of the hospital: (1) the salary structure of the hospital, it was felt, was low in relation to that of other hospitals in the Chicago area; (2) the rates being paid for certain positions in the structure were based, in a considerable number of instances, upon the pull and tug of individual pressures and upon the normal rivalry existing among professional groups; (3) there was no systematic arrangement for rewarding meritorious employees, and (4) adequate job descriptions were not available.

It should be mentioned that these conditions were not unique to Provident Hospital, at that time. They were, and still are, present in many other hospitals to varying degrees, as well as in many industrial establishments throughout the country.

After studying the possible methods of improving these conditions and establishing a well rounded wage and salary structure, the board of trustees selected a consulting management engineering firm to undertake a job evaluation study of the hospital situation.

Clyde L. Reynolds, executive director of the hospital, was placed in administrative charge of the program. In order to assure the hospital's having a person fully acquainted with all details of the program, and at the same time keep the consulting service costs at a minimum, the administrative assistant of the hospital staff was selected to participate fully in each step of the procedure under the engineer's supervision.

After due consideration, it was decided that the scope of the study would include all positions of the hospital from the starting, routine positions up to and including the departmental supervisors, and would encom-

pass all clerical, operating, maintenance, technical, nursing and administrative positions in the organization.

Inasmuch as the success or failure of such a program rests to a considerable degree upon the cooperation of the departmental supervisors, a group meeting was held with them at which complete explanation was given as to why the study was being undertaken, how it was to be done, the extent of their participation in the program, and the anticipated results. As was to be expected, numerous questions arose among this group and a frank answering of these questions tended to allay any doubts or suspicions that the supervisors had. Each was given a job analysis form for the positions under his supervision, along with a thorough explanation of the meaning of the factors contained in the form.

Each was then given the assignment of supplying the information

necessary to give an adequate word picture of each position. The men assigned to the execution of the program were made available to give assistance or advice. In most instances the supervisors required some help since that type of activity was foreign to the normal supervisory position duties. Subsequent meetings were scheduled with each department supervisor by the assigned engineer and administrative assistant in order to get the job analysis phase of the program under way.

Upon completion by a department supervisor of the job analysis form for each separate and distinct position the forms were thoroughly checked to assure the accuracy of the detailed statements describing education, experience, skill requirements, working conditions, contacts and other characteristics having a bearing on the value of the position. Assistance was also

Provident Hospital and Training School Salary Progression Plan

Salary Grade	Minimum	6 Mo.	1 Yr.	2 Yr.	3 Yr.	4 Yr.	5 Yr.	Maximum
1	\$100	\$105	\$110	\$120	\$130	\$140	—	\$140
2	115	120	125	135	145	160	—	160
3	130	135	140	150	160	170	\$180	180
4	145	150	155	165	175	185	200	200
5	160	165	170	180	190	205	220	220
6	180	185	190	200	215	230	245	245
7	200	—	210	225	240	255	270	270
8	220	—	235	250	265	280	295	295
9	240	—	255	270	285	300	320	320
10	260	—	275	290	310	330	350	350
11	280	—	300	320	340	360	380	380
12	305	—	325	345	365	390	415	415
13	330	—	350	375	400	425	450	450

1. July 1, 1949, will be considered as the beginning date for the establishment of the salary progression plan.

2. Employees receiving salary increases as of Sept. 1, 1949, will be given consideration for a merit increase to the next higher time step on July 1, 1950, and at each succeeding year thereafter.

3. Employees not receiving salary increases as of Sept. 1, 1949, will be given consideration for a merit increase to the next higher time step on Jan. 1, 1950, and at each succeeding year thereafter.

4. No employee whose salary rate is above the maximum of the salary grade occupied will be increased in rate as long as that employee remains in the same job classification.

5. New employees will be hired at the minimum of the salary range for the job classification, and future increases in salary will be in accordance with the salary progression plan.

6. In those cases where employees are in classifications whose salary standards are governed by professional practice, extreme care should be exercised to avoid exceeding those standards even though the salary range for those classifications would permit upward movement.

JOB ANALYSIS

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Description of Duties (Continued)

Job Title
CHIEF TECHNICIAN (X-Ray)

Names of Employees in this job

Location and Sub-Location of Place of Work
President Hospital - 2nd Floor
Department
X-Ray
Division
X-Ray
Group or Section
X-Ray
Immediate Supervisor-Give Title and Name
Chief Radiologist, Dr. Wm. F. Quinn
Supervisor next in Charge-Title and Name
Executive Director-Claude J. Barville

DESCRIPTION OF DUTIES:

1. General Summary Statement of kind, nature and scope of work performed.
2. Details as to the various steps or operations:
 - a. Regular and daily.
 - b. Periodic, but less often than daily.
 - c. Occasional, special, exceptional, or irregular.

1. Under semi-direct supervision, to assist the Radiologist in all phases of the X-ray Department, including the taking and technical analysis of X-ray film, the maintenance of equipment, and the instruction of Technician-Trainees.

2. A Assist the Radiologist in the taking and analyzing of X-ray film by preparing and positioning patients, making standard or requisite number of negatives and collaborating in the analysis of radiographs from a technical standpoint.

Operate X-ray apparatus through the use of controls necessary to govern correct exposure factors.

Be responsible for the maintenance of X-ray equipment by making minor repairs, keeping all surfaces and exposed parts clean, and checking exposure factors to prevent overload.

Instruct the assigned Technician-Trainees in the following courses:

Physics	Positioning Patients
X-ray Equipment	X-ray Techniques
Dark Room Procedures	Record Keeping
Dark Room Chemistry	

B Develop X-ray film in accordance with proper dark room technique, using necessary chemical solutions and washing and drying procedures.

Prepare solution of developer and fixer by mixing of required chemicals and maintaining correct temperature levels.

C Perform other related work as required or assigned.

These are the four pages of a typical job analysis form filled out by a representative of the consulting engineers. The information contained in this form includes a complete description of the duties and analysis of factors bearing on the value of the job.

(Add supplementary insert sheets if necessary)

RATING FACTORS

A. EXPERIENCE, KNOWLEDGE AND SKILL

1. Previous Experience Required. Show range and length of previous experience required, in related or lower jobs, necessary as preparation for or leading up to the particular job being rated. Wherever possible indicate experience within the hospital.
One year or more of intensive training under the direction of a Radiologist

2. Specialized or Technical Education Required to Enter the Job as Distinguished from Working Experience.
Education equivalent to graduation from high school, supplemented by one year of didactic training in recognized X-ray techniques.

Reserve this Space

A. EXPERIENCE, KNOWLEDGE AND SKILL

3. Manual or Physical Skill Required. Show skill of hand operations or other coordinated series of muscular habits and motions; precision and dexterity required.

Hand-eye coordination is required in operating and making minor repairs to X-ray equipment, as well as in the positioning of patients.

4. Physical effort required. Show features of muscular exertion, considering intensity, duration, variety, severity, difficulty of work position and the like.

Lifts, moves, and positions patients in accordance with their particular requirements. Stands and walks a majority of the work period.

B. WORK COMPLEXITIES

5. Complexity and Difficulty of Work (see description of duties).

Seriousness of Errors. Show the kind of errors, the frequency with which they may occur, and the relative magnitude and importance of the consequences resulting from such errors.

Close attention is required to avoid X-ray equipment operating errors which would result in destruction of tubes, transformers, and other components. Lack of proper diligence in noting equipment condition, and failure to make or report necessary maintenance work would cause equipment deterioration.

C. WORKING CONDITIONS

7. Hazards. Show source and kind, frequency, variety, extent and seriousness of danger from accident and of risks to health.

Fairly constant exposure to dangerous low-grade radiation could result in leukemia, sterility, or skin cancer. Tuberculosis and other contagious diseases could be contracted from patients.

8. Adverse Working Conditions. Show those physical conditions surrounding the work performed that are disagreeable, uncomfortable or otherwise adverse in nature including the frequency, variety and intensity or severity of such conditions.

Occasionally works in the dark room for extended periods while developing X-ray film.

D. CONTACTS

9. Contacts with Patients, the General Public, Other Hospitals, or Companies. Indicate the organizational level of people in other hospitals or companies dealt with; the type, difficulty and importance of transactions handled and the potential effects of such contacts on hospital good will.

Daily personal contact with patients preparatory to and during the X-ray examination. Such contacts require tact and diplomacy, particularly in regard to the admitting sequence.

10. Contacts with Other Departments. Indicate type, volume, importance and difficulty of transactions handled with other departments.

Daily personal and telephone contact with all medical departments of the hospital concerning the making or revising of daily appointments.

Reserve this Space

E. RESPONSIBILITIES

11. Responsibility for the Safety of Others. Show the extent of responsibility for protecting, safe-guarding or eliminating hazard to fellow employees or the general public, or for protecting, safeguarding, and administering medical care to patients.
Responsibility is two fold: (1) personally responsible for the protection of patients prior to treatment, e.g. movement and positioning, and for the proper exposure factor necessary to prevent radiation reactions; (2) possesses supervisory responsibility for the training of 8 or 9 Technician-Trainees in accordance with safe working regulations.

12. Responsibility for Hospital Funds or Property. Show the extent of responsibility for protecting, safeguarding and assuring proper use of Hospital funds or property.
Secondarily responsible for the care, protection, and use of expensive X-ray equipment, and for the control and use of X-ray film.

13. Responsibility for Confidential Information. Show the extent of responsibility for use of confidential data and the need for discretion, caution, and carefulness in use and protection of such material.
Responsibility requires the confidential treatment of data pertaining to patients' medical condition.

14. Responsibility for Performance of Work Without Immediate Supervision. Show the proximity and frequency of supervision received, as well as the degree to which employee is instructed and the extent to which the work performed is subject to observation, inspection or checking.
Supervisor is present usually only one-half of working period but is available by telephone for emergency problems. Wide latitude exists for the selection of proper X-ray methods and procedures. Generally only the finished product is checked by supervisor.

15. Responsibility for the Supervision of Others. Indicate number and kinds of jobs supervised and requirements as to the directing, instructing, and training of personnel, and planning, controlling and supervising the work of others.
Plans, controls, assigns and directs the development program of 8 or 9 Technician-Trainees. This responsibility is carried out by both lecture and clinic methods.

Reserve this Space

Analysis Prepared By (Name and Title)

Edward R. Barker - Senior Engineer - Business Research Corporation

given in the classification of employees into the different types of work, and other pertinent questions were answered. The forms were then given to representative employees in each classification for review. Any modification of the original material, as suggested by them, was shown to the supervisor and, when valid, was incorporated into the job analysis form. The executive director then reviewed the information and suggested revisions where necessary. The completed job analyses were then ready for use in the evaluation phase of the program.

All jobs in the study were then evaluated by use of the following 15 factor point rating scale:

JOB RATING SCALE	
Experience, Knowledge, Skill (110)	Weight
1. Previous experience required	40
2. Specialized or technical education required	40
3. Manual or other physical skill required	20
4. Physical effort required	10
Total	110
Work Complexities (115)	
5. Complexity and difficulty of duties	90
6. Seriousness of errors	25
Total	115
Working Conditions (40)	
7. Hazards	30
8. Adverse working conditions	10
Total	40
Contacts (50)	
9. Contacts with patients, the general public, other hospitals or companies	40
10. Contacts with other departments	10
Total	50
Responsibilities (185)	
11. For safety of others	35
12. For hospital funds or property	15
13. For confidential information	15
14. For performance of work without immediate supervision	20
15. For supervision of others	100
Total	185
Grand Total	500

This job rating scale, with step definitions under each factor, provided for a weighted consideration of the various factors. It had been carefully developed to achieve a proper balance between the ratings assigned to each position under the factors entering into the evaluation.

A rating committee was created consisting of four members, namely, the executive director, the administrative assistant, the department supervisor of the positions being rated, and the representative of the engineering firm, the last acting as leader, co-

ordinator and guide in the rating of the positions and in the application of the rating scale.

The rating committee, in conference, evaluated each series of positions, factor by factor, with the rating scale as a guide. The bases for the ratings were the job analysis forms and the committee's combined knowledge of the positions. In the rating process, positions were discussed in detail and an agreement upon the point value of each factor was arrived at before proceeding to the next position or factor. The ratings as agreed upon were recorded on a "Summary of Point Ratings" form. The result of the rating process was to produce a total over-all point rating for each position, which indicated the relative value and importance of the various positions.

The next step in the procedure was to construct an evaluation graph with salaries as ordinates and rating points as abscissae. A "scatter diagram" resulted when the salary and point ratings were plotted for each position. A weighted average trend line was then computed on the basis of an equal distribution of points and monthly salaries above and below this line.

In order to determine the exact relationship of the Provident Hospital pay roll structure to those of other hospitals in the area, it was necessary that comparative pay information be obtained. Using the completed job analysis forms for 15 key positions in the hospital service as a basis of comparison, contact was made with other hospitals in the Chicago area to determine their rates of pay for each of the positions. A study was also made of the salary rates paid by Chicago industry for like positions. This information was then plotted for the various positions using the same axes as in the evaluation graph previously mentioned, and was superimposed upon the evaluation graph in order to check the pay relationship. This study indicated that the Provident Hospital salary structure was approximately 9 per cent low for the lowest rated positions and 7 per cent low for the highest rated positions. A new trend line was drawn, which brought the hospital's salary structure in line with other Chicago hospitals and industry.

In order to simplify the hospital's salary administration, positions were consolidated into salary grades, and minimum and maximum salary lines were drawn 15 per cent below and above the median of the trend line for

each grade. These salary grades are as follows.

Salary Grade	Range of Point Ratings	Salary Range	
		Minimum	Maximum
1	0-19	\$100	\$140
2	20-32	115	160
3	33-46	130	180
4	47-61	145	200
5	62-77	160	220
6	78-94	180	245
7	95-112	200	270
8	113-131	220	295
9	132-151	240	320
10	152-172	260	350
11	173-194	280	380
12	195-217	305	415
13	218-241	330	450

These salary grades were then adopted as the basis for the hospital's salary administration program; however, certain working rules were needed for the efficient operation of the program. These rules were outlined in a salary progression plan.

In order to correct the inequitable conditions found in the old structure, immediate increases were given to incumbents of job classifications whose salary rates were beneath the minimum of their respective salary grades.

The next step necessary to activate the structure was to determine which of the employees should be awarded merit increases within the salary grades. In the absence of a merit rating plan, which will be set up in the near future, meetings were held by the executive director with the departmental supervisors in order to review each employee's work record and accomplishments. Deserving employees were then recommended for increases at least up to the next time step in the salary progression plan. Future increases for these individuals will be considered on the basis of the time periods and for the amounts outlined in the plan.

Job descriptions consisting of a summary statement of the principal duties, and detailed information as to basic duties of the job, responsibilities, immediate supervisor, qualifications and lines of promotion were then prepared from the job analysis form and from supplementary information furnished by the supervisory personnel. These job descriptions will be of value in the original selection, training and promotion of the employees, in job comparison studies, and in similar matters conducive to successful salary administration.

The complete program was reviewed with the Provident Hospital board of

COMPANY PROVIDENT HOSPITAL

DATE July 1949

POSTAL SERVICE 1 DAY

DATE July 1949

DATE July 1949

TITLE OF POSITION	Total Points	A. Experience (years and months)				B. Work Experience				C. Working Conditions				D. Contacts				E. Responsibilities			
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
PHARMACEUTICAL																					
Pharmacist	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacist Assistant	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacist	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Chief Pharmacist	173	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
PHYSICIAN																					
Physician Therapist	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Registered Physical Therapist	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical Therapist (B.S.)	163	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
SOCIAL SERVICES																					
Clerk	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secretary	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Registered Nurse	106	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Nurse	126	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Psychiatric Social Worker	170	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Librarian																					
LABORATORY																					
Clerk	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medical Researcher	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Chief Technician	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

REMARKS: IT IS THE POLICY OF THE COMPANY TO ADVANCE

trustees and its approval was received for its inception.

The executive director then met with each of his supervisors individually and explained each phase of the job evaluation program. Particular emphasis was placed upon those events which had taken place since the rating of the position of each had been completed.

To guide them in the initial presentation of the program to their employees and in their future administration of the program, the supervisors were presented with a complete set of job descriptions for their department along with the departmental salary progression plan. With this information, the supervisors will be able to discuss job requirements intelligently with their employees, as well as their salary progress. The supervisors then met with employees in the different job classifications under their

direction, outlined the purpose, procedure and results of the job evaluation program, and explained starting rates, time steps, salary grade maximums, as well as the job descriptions.

A job evaluation once made is not a permanent thing. It has to be adjusted to keep pace with organization changes, revision in duties of positions, increased or decreased responsibilities, and so forth. Therefore, to maintain a job evaluation at its maximum usefulness, it is necessary to make definite provision for its revision from time to time, as required. In order to fulfill this need, the administrative assistant was given the assignment of keeping the program current.

His duties will consist of preparing an adequate job analysis and job description for new positions and for those whose duties are changed or revised. He will assist in evaluating these new or revised positions, using

the rating scale which was employed in rating the other positions in the hospital. From the point ratings so obtained, he will then fit the positions into their proper place on the graph of the evaluation and will determine the appropriate salary range from the graph.

The benefits to be derived from this program are: (1) employee grievances or dissatisfactions growing out of wage inequities are eliminated; (2) the uncertainties regarding position duties and responsibilities are removed; (3) the scope of each position is clearly defined and the lines of promotion are definitely established; (4) accurate information is immediately available for use in hiring and in transferring employees to other positions, and (5) supervisors and other employees understand the facts of the salary structure and the reasons for the differences in salary rates among positions.

Teamwork is the answer to obtaining

Authorization for Necropsies

W. G. HARTNETT, M.D.

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Formerly, Chief, Professional Services, Veterans Administration Hospital, and Instructor in
Clinical Medicine, Baylor University College of Medicine, Houston, Tex.

AT THE time this report was written, the Veterans Administration Hospital at Houston, Tex., had been in operation for five months. During this time there were 73 deaths in the hospital. Of the 73 deaths, consent for necropsy was obtained in 68 cases. This is a percentage of 93.2. For the month of April there were seven deaths with four necropsies, for our lowest percentage of 57.1. During the month of April the hospital was undergoing organization, and the "necropsy team" was not in full swing. In May there were 11 deaths and 11 necropsies. In June there were 16 deaths with 15 necropsies; in July, 27 deaths with 26 necropsies; in August, 12 deaths with 12 necropsies.

Published with consent of Deans Committee, Baylor University, and Manager, Veterans Administration Hospital, Houston.

Our method of getting permission for necropsy is unique. It could be followed in a great many other hospitals. The success could not be attributed to any one individual factor, but to an aggregation of many small factors. One of the biggest elements in obtaining a necropsy is a satisfied family. When the family feels that everything possible was done for the deceased, and is appreciative of the service, it is much easier to convince it of the good of a necropsy. We have used this psychology in the hospital ever since it was opened. We have attempted to convince both the patient and the family that better care cannot be given in the state of Texas than we can give here in the V.A. Hospital in Houston.

Both patients and relatives are cognizant of the fact that we are a teach-

ing hospital and have the consultant services of some of the best physicians in Houston. Any complaints from patients or relatives are promptly investigated by the manager or chief of professional services or the chiefs of the various services and are rectified to the satisfaction of those concerned. Inspections are accomplished in the hospital once a week by the chief of professional services and the executive officer, at which time the patients on every ward are questioned regarding the quality of service, *i.e.* whether the food is good or is hot enough when served, whether the nursing service and the attendant service are satisfactory, and whether the patient has any complaints regarding his medical treatment. This procedure, I believe, convinces the patient that we are all interested in everything concerning him.

When the patients are placed on the "Seriously Ill" and "Critically Ill" lists, the families are permitted to visit the patients at any hour of the day or night. Relatives are particularly appreciative of this service, as they have frequently been excluded from private hospitals at the end of visiting hours regardless of the patient's condition.

When the patient expires, then the necropsy team goes into action. The team consists of, first, the resident; second, the chief of appropriate service; third, the details clerk of the registrar's division, Mrs. Helen Hutchinson; fourth, the chaplain; fifth, the pathology department, and, sixth, the chief of professional services. The necropsy team may work either as individuals or in a group, as the case demands. The primary thought is that we do not take "no" for an answer until all possibilities have been explored. If the resident is unable to obtain consent, he refers the relatives to the chief of service, who explains, as well as possible, what good may come to the family, the scientific value, and so on. If he is not successful, the people are referred to the details clerk.

Our pathologist, Dr. Mervin Grossman, is a faculty member at Baylor Medical School. He is extremely interested in teaching and was largely responsible for the indoctrination of our details clerk. She is probably our greatest asset in getting consent.

CLERK IS SYMPATHETIC

Our details clerk, who is a woman of about 30 years, is a friendly individual. She is a very sympathetic sort and seems to be able to adjust her personality to fit all types of persons. She is thoroughly interested in her job, and she, herself, is *completely* convinced of the value of a necropsy.

Usually in her interview with the surviving relative, she has one or more doctors present, as well as the chaplain. The psychology of people suddenly bereft of a relative is not the same as it is under normal circumstances. Our details clerk seems to sense the proper approach, and the approach may be different for each case.

Since she deals with people of all intellectual levels, she must convey her ideas to each individual. To the more intelligent, her appeal is on a scientific basis, explaining what good may come from the scientific study of the body. She believes that persons who have lost someone in death want to do

something for other people, and she stresses this point of helping other sick persons. If she meets with objections, she has a clear-cut answer. Having the chaplain and the doctor present, she can get their help in answering the objections.

She explains how necropsy findings make a case complete and how the examination will remove any doubt from the relatives' minds as to the actual cause of death. Many cases may have an insurance angle, and she explains how an accurate diagnosis from a pathological examination may aid in collecting the insurance. Particularly is this point important in the case of veterans whose final illness may have been influenced by some illness which they incurred while in the service.

SEEKS HELP FROM FRIENDS

Many times the details clerk has made use of friends of the deceased who were on the ward during his illness. These people have sometimes met the family, and the details clerk has occasionally been able to stress the importance of a postmortem examination to these friends. The friends have then prevailed upon the family to give authorization for the necropsy.

If she sees that the family is reluctant about giving consent, she drops the subject and tells the relatives how the government wants to help the family, that the government stands ready to pay all funeral expenses and make all burial arrangements. Then when the nearest relative finishes saying how much he appreciates all the government is trying to do, the details clerk again brings up the subject of necropsy and usually succeeds in getting the authorization.

The last approach is financial. She explains how the family may benefit financially if the patient could have died from anything even remotely connected with his military service. She cites cases in which necropsy established such diagnoses. She explains the right of widows to pensions if veterans have died of any illness connected with military service.

If all of this fails, she brings the relatives to the chief of professional services, who makes one last try at getting authorization.

We have been able to establish good rapport with the various undertakers. This has been accomplished by having the death certificates ready for them when they call for the body and

by having taken extreme care to prevent making their job more difficult. The vessels are left as long as possible and long ties are left in for their easy identification. On several occasions this has resulted in the difference in whether or not we get the postmortem. The "friendly undertaker" has a lot of influence on the family, and several times we have lost permission for necropsy because undertakers objected to them on the basis that interns or inexperienced people from other institutions have left bodies so that it was difficult for them to work.

The idea of refusing to admit defeat has obtained consent for necropsy in some of our more difficult cases. We have used the telephone freely for long distance calls to the next of kin. Many times a son or daughter has refused consent, while the wife, when we got in touch with her, has readily acquiesced. The children have frequently tried to prevent our reaching the next of kin, such as a separated wife. In such a case, we have the advantage of having a veteran's record back to his period of military service. Often a veteran is separated, but not legally divorced from his wife. Since she is the next of kin legally, we get in contact with her and are frequently able to get permission for necropsy.

GET AUTHORIZATION QUICKLY

We have also found that it pays to get authorization as soon as possible after the patient has expired. If much time has elapsed and members of the family have mulled it over in their minds or talked with an undertaker, it is more difficult to obtain consent than if the relatives are approached at an earlier time. Many undertakers take the attitude that posting a body makes it much more difficult for them to do their work. So, if possible, we try to get consent before the body goes into the hands of the undertaker.

I believe that a low rate of necropsy in any hospital reflects a lack of interest in obtaining consent for postmortem examinations. If the resident feels that he has done his duty merely by asking the relatives and getting a "no" for an answer, a high rate will never be achieved. The entire professional staff must be interested in getting the necropsy rate as close to 100 per cent of the deaths as is possible. A planned procedure or a team such as ours would simplify this matter in all hospitals, whether federal or private.

Small Hospital Forum

HOW THEY CHARGE FOR LABORATORY SERVICES

LABORATORY fees in small hospitals throughout the country reveal considerable uniformity in most of the low-cost examinations and procedures, a survey of charges now being made to patients reveals. The study of laboratory charges covered 55 hospitals ranging from 50 to 100 beds in size. The average size of the hospitals in the group was 73 beds.

As shown in the accompanying tabulation of reported charges in these hospitals, such procedures as red and white blood count, differential cell count, blood chemistry, coagulation time and hemoglobin determinations are, for the most part, standardized at charges which are fairly uniform from section to section of the country and in hospitals of various sizes within this particular group. On the other hand, wide variations in the amount charged for services begin to emerge in reports of current rates for basal metabolism tests, gastric and sputum analyses, tissue pathology, spinal fluid examinations and other more expensive procedures.

NO REGIONAL VARIATION

No significant variation on a regional basis can be developed from rates reported in this particular study. While it appeared that rates in the Midwest and Southwest were somewhat higher for a number of specific services than those reported by Eastern and Southern hospitals, some of the reported charges emerge as exceptions to this general rule, and, furthermore, the number of hospitals in each region was too small to permit any such general inference to be drawn.

The charge for blood counts varied from as little as 50 cents in one hospital to a high of \$3.50 in one or two other institutions. Ruling out the relatively few institutions still charging \$3

or more for each cell count examination, however, the charge for this service is fairly well established between limits of \$1 and \$2, the survey revealed. For example, the average charge for red blood counts in New England hospitals covered in the survey was \$1.08. The charge in hospitals in the Middle Atlantic States was \$1.52; Midwest hospitals charge \$1.47 for the red blood count, while charges in the South, Southwest and West are \$1.19, \$1.40 and \$1.30, respectively.

Charges for white blood count are almost precisely the same as for the red count, and the differential cell count, when charged separately, is either the same or a few cents more throughout the group. Many of the hospitals reported that for most patients red, white and differential cell counts are grouped in a single charge, which varied from \$3 to \$5 in these hospitals.

Similarly, hemoglobin and coagulation time determinations range from \$1 to \$2 in all but a few hospitals which are under or over these limits. The blood chemistry charge, however, revealed a somewhat wider variation, with a few hospitals charging as little as \$2 and one or two as much as \$10. At \$3.62, the national average of reported charges for this service reflected a fairly uniform rate in all sections of the country.

Many of the hospitals in this group send blood to local or state public health laboratories for Wassermann

tests, it was revealed in the survey. Where this work is done by the hospital, however, the charge varies from \$1 to as much as \$5. The average for all hospitals is \$2.42.

The average basal metabolism charge in all the hospitals was \$6.46. Again, the average reflected a fairly uniform rate among hospitals in various sections of the country, although individual charges ranged from \$5 to \$10. An even wider range was reflected in the reported charges for tissue pathology examinations. The average charge for this service was \$5.74, reflecting regional differences from the low charge of \$4.35 for Southern hospitals to a high of \$7.10 for those in the far West. The individual range was from a low of \$2 in one Southern hospital to a high of \$10 in several New England institutions.

FROM \$2.50 TO \$10

Gastric analysis also reflected a wide variation in charges ranging from \$2.50 in one institution in the Middle West to \$10 in several hospitals reporting from Middle Atlantic, Midwest and Western hospitals. Similar variations were noted in the charge for sputum and feces examinations.

The greatest variation in all charges, however, appeared in the rates reported for spinal fluid examinations. These charges averaged \$6.38 per examination for the entire group of hospitals, but ranged from an average charge of \$3.60 in the Southwestern group to a high of \$11, on the average, in the far West. The reports from individual hospitals indicated that there may have been some misunderstanding as to the procedure covered, since some hospitals reported that spinal fluid examination was charged at only \$1 while others indicated charges ranging up to \$15, \$16 or even \$20.



LABORATORY SERVICE RATES IN SMALL HOSPITALS

REGION	BEDS	BASAL METAB.	DIFF. CELL C.	R.B.C.	W.B.C.	BLOOD CHEN.	COAG.	HEMO. GLOBIN	WASSER- MANN	FECES	SPUTUM	SPINAL FLUID	GASTRIC ANALYSIS	TISSUE PATHOLOGY	URINE
NEW ENGLAND	46	\$7.50	\$1.25	\$1.25	\$1.25	\$2.50	\$0.75	\$1.25	\$1.25	\$2.50	\$2.50	\$2.50	\$5.00	\$4.50	\$1.25
	60	10.00	2.50	1.00	1.00	\$3.50	1.00	1.25	N.C.	7.00	3.00	10.00	5.00	10.00	1.00
	70	10.00	2.50	1.00	1.00	2.00	1.00	1.00	N.C.	7.00	3.00	10.00	5.00	10.00	1.00
	75	5.00	2.00	1.00	1.00	2.00	1.00	1.00	N.C.	3.00	3.00	7.50	3.00	3.00	1.00
	70	5.00	1.00	1.00	1.00	3.00	1.00	1.00	1.00	—	1.00	8.00	5.00	10.00	1.00
	50	5.00	1.00	1.00	1.00	3.00	1.00	1.00	1.00	—	1.00	2.50	5.00	10.00	2.00
	50	5.00	1.00	1.00	1.00	3.00	1.00	1.00	1.00	—	1.00	2.50	5.00	10.00	2.00
	52	10.00	2.00	1.00	1.00	3.00	1.00	1.00	1.00	1.00	1.00	2.00	3.00	10.00	1.00
	73	5.00	1.00	1.00	1.00	3.00	1.00	1.00	1.00	1.00	3.00	3.00	5.00	5.00	2.00
	104	5.00	1.50	1.50	1.50	3.00	1.00	1.50	1.00	6.00	7.00	11.00	4.00	7.50	1.50
AVERAGE	83	10.00	2.00	1.00	1.00	5.00	1.00	1.00	2.00	—	—	5.00	5.00	5.00	2.00
	55	5.00	1.00	1.00	1.00	5.00	2.00	1.00	2.00	—	—	—	—	—	—
	65	\$6.42	\$1.42	\$1.08	\$1.14	\$3.61	\$1.14	\$1.06	\$1.58	\$3.50	\$2.75	\$5.59	\$4.50	\$6.72	\$1.35
	108	5.00	1.00	3.00	3.00	4.00	1.00	1.00	—	6.00	3.00	1.50	3.00	—	1.50
	70	8.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	7.50	3.00	5.00	3.00	5.00	1.00
	118	10.00	1.66	1.66	1.66	1.00	1.00	1.00	2.00	4.00	3.00	5.00	3.00	5.00	1.00
	99	5.00	1.00	1.00	1.00	2.50	1.50	1.00	3.00	5.00	5.00	3.00	5.00	5.00	1.00
	99	5.00	2.00	1.00	1.00	5.00	1.00	1.00	2.50	5.00	5.00	7.50	5.00	5.00	1.00
	104	10.00	3.00	2.00	2.00	4.00	2.00	2.00	3.00	5.00	3.00	16.00	10.00	10.00	1.00
	50	5.00	1.00	2.00	1.00	3.00	1.00	1.00	—	—	3.00	—	—	—	—
MIDWEST	88	\$7.00	\$1.52	\$1.52	\$1.41	\$3.94	\$1.29	\$1.22	\$2.50	\$5.79	\$3.66	\$6.33	\$6.12	\$5.35	\$1.19
	52	6.00	2.00	1.00	1.00	4.00	.50	1.00	1.00	3.00	3.00	5.00	3.00	5.00	1.00
	72	7.50	2.00	3.50	3.50	4.00	2.00	2.00	5.00	7.50	10.00	20.50	7.50	8.00	2.00
	73	6.00	3.00	3.00	3.00	4.00	1.00	1.00	2.00	3.00	3.00	2.00	5.00	5.00	2.00
	100	6.00	1.00	1.00	1.00	4.00	1.00	1.00	1.00	8.00	4.00	6.00	6.00	6.00	1.50
	80	5.00	3.00	1.00	1.00	3.00	1.00	1.00	1.00	3.00	2.00	5.00	5.00	5.00	1.50
	77	5.00	1.75	1.75	1.75	5.00	1.00	1.25	2.00	5.00	2.00	5.00	5.00	5.00	1.50
	105	5.00	1.00	1.00	1.00	3.00	2.00	1.25	2.00	5.00	1.00	6.00	5.00	5.00	2.00
	50	5.00	1.25	1.25	1.25	4.00	—	1.25	4.00	2.00	1.25	1.25	2.50	4.50	1.25
	100	6.00	1.00	1.00	2.00	5.00	1.50	1.00	2.00	5.00	5.00	5.00	5.00	5.00	2.00
SOUTH	77	\$6.43	\$1.57	\$1.47	\$1.54	\$3.93	\$1.13	\$1.17	\$2.37	\$4.16	\$3.15	\$6.68	\$5.80	\$5.75	\$1.74
	77	5.00	1.75	1.75	1.75	3.00	3.00	.75	3.00	3.00	1.50	8.00	5.00	—	1.00
	50	5.00	1.00	1.00	1.00	2.00	1.00	1.00	2.00	1.00	1.00	8.00	3.00	3.00	1.00
	75	5.00	1.00	2.00	2.00	5.00	1.00	1.25	5.00	2.00	2.00	7.50	5.00	4.50	2.00
	62	5.00	1.25	1.25	1.25	3.00	1.00	1.25	5.00	2.00	2.00	5.00	5.00	5.00	2.00
	35	5.00	1.00	1.00	1.00	3.00	1.00	1.00	2.00	1.00	1.00	8.00	5.00	5.00	1.00
	99	5.00	1.00	1.00	1.00	2.00	1.00	1.00	1.00	1.00	2.00	5.00	5.00	5.00	1.00
	66	\$5.93	\$1.25	\$1.19	\$1.19	\$3.00	\$1.25	\$1.12	\$3.00	\$2.62	\$1.49	\$5.81	\$4.56	\$4.35	\$1.50
	60	5.00	2.00	3.00	3.00	5.00	1.00	1.00	1.00	2.00	2.00	2.00	5.00	5.00	1.00
	99	5.00	1.00	1.00	1.00	2.50	1.00	1.00	2.50	5.00	5.00	5.00	5.00	5.00	1.50
	84	5.00	1.00	1.00	1.00	3.00	2.00	1.00	4.00	2.00	2.00	1.00	5.00	5.00	2.00
WEST	77	\$5.00	\$1.20	\$1.40	\$1.40	\$5.30	\$1.75	\$1.00	\$2.50	\$4.00	\$3.60	\$3.60	\$4.80	\$5.10	\$1.50
	100	7.50	1.50	1.25	1.25	3.50	1.00	1.00	2.50	5.00	1.50	10.00	7.50	6.50	1.50
	58	10.00	1.50	1.50	1.50	3.00	1.50	1.50	2.50	7.50	5.00	15.00	10.00	7.50	2.00
	58	10.00	1.25	1.25	1.25	5.00	2.50	1.50	2.50	7.50	2.00	10.00	5.00	7.50	1.00
	58	10.00	1.50	1.50	1.50	3.00	1.00	1.00	—	7.50	3.00	10.00	7.50	7.50	1.50
	65	\$8.00	\$1.30	\$1.30	\$1.30	\$3.40	\$1.30	\$1.00	\$3.33	\$5.90	\$2.60	\$11.00	\$7.50	\$7.10	\$1.50
	73	\$6.46	\$1.42	\$1.32	\$1.32	\$3.62	\$1.24	\$1.08	\$2.42	\$4.18	\$2.88	\$ 6.38	\$5.43	\$5.74	\$1.43
NATIONAL AVERAGE															

About People

Administrators

William B. Woods has been named hospital supervisor of the Rochester Municipal Hospital, which is adjacent to, and an integral part of Strong Memorial Hospital of the University of Rochester. Mr. Woods succeeds **George J. Dash**, who held this post from 1934 to 1949. Mr. Woods is a graduate of Alfred University, where he received his A.B. degree in 1947; he obtained his master of science degree in hospital administration at the School of Public Health, Columbia University, in 1949. During the war, he served four years in the army medical corps, including two years in the European theater. He has been an administrative assistant at Strong Memorial Hospital since June 1948.



W. B. Woods

Dr. T. Bruce H. Anderson, medical officer in charge at the 780 bed U.S. Marine Hospital, Stapleton, Staten Island, N.Y., has retired from the Public Health Service to become administrator of the Marshall Memorial Hospital and the Guggenheim Memorial Hospital, both at Lynchburg, Va. Dr. Anderson has been medical officer in the Public Health Service for 35 years, and head of the Staten Island hospital since 1944. **Dr. John A. Trautman**, medical officer in charge at the Marine Hospital in Cleveland, will take Dr. Anderson's place on July 1. Until then the hospital will be headed by **Dr. John W. Bowden**, deputy medical officer in charge.

Dr. Robert C. Hunt has been appointed director of St. Lawrence State Hospital, Ogdensburg, N.Y., succeeding **Dr. John A. Pritchard**, who retired recently after 10 years as head of the hospital. Dr. Hunt was formerly assistant director of Rochester State Hospital, with which he was associated from 1935 until his present appointment, except for military leave of absence between 1942 and 1946.

E. C. H. Pearson has resigned as superintendent of Salt Lake County General Hospital, Salt Lake City, Utah, to become superintendent of French Hos-

pital, San Francisco. He will assume his new duties on April 3.

William F. Andrews, recent graduate of the hospital administration course at Duke Hospital, Durham, N.C., has been named administrator of the C. J. Harris Community Hospital, Sylva, N.C.

Robert E. Wallace has resigned as assistant administrator, Peoples Hospital, Akron, Ohio.

Dr. John H. Linson, who has been in charge of various U.S. Marine hospitals for many years, retires April 1 from the Public Health Service. For the last year he has been medical officer in charge of the U.S. Quarantine Station and Out-patient Clinic, San Diego, Calif. During his career in hospital administration, Dr. Linson has been clinical director at the Marine hospitals in New York, Chicago, and Norfolk, Va. He was in charge of the Detroit Marine Hospital from 1930 to 1935 and again from 1945 to 1947.

Eric G. Landbert, a student in one of the first classes in the program in hospital administration at Northwestern University, and former business manager of Grant Hospital, Chicago, has been named business manager at Abbott Hospital, Minneapolis. He plans to continue his studies in hospital administration at the University of Minnesota.

Earl Dresser, formerly administrative assistant at Abbott Hospital, Minneapolis, has assumed the responsibilities of administrator of Decorah Hospital, Decorah, Iowa. Mr. Dresser is a graduate of the University of Minnesota and the school of hospital administration at the university.

Russell N. Tucker, administrator of Cushing Municipal Hospital, Cushing, Okla., has been named administrator of Hilo Memorial Hospital in Hilo, Hawaii, T.H. He will succeed the late **John A. Lindner** whose death was reported in these columns in February. Before going to Cushing, Mr. Tucker was assistant administrator of Mercy Hospital, Oklahoma City, Okla.



R. N. Tucker

Harvey S. Van Vlear, business manager of San Joaquin General Hospital, French Camp, Calif., since 1942, has left that position. He has been succeeded by **Thomas Le Mieux**, formerly assistant business manager.

Dr. Russell H. Frost is the new superintendent and medical director of Buena Vista Sanatorium, Wabasha, Minn. He was formerly associated with G. B. Cooley Sanatorium, Monroe, La.

Dr. Glen W. Doolen, chief of the Tuberculosis Section of the Veterans Administration Area Medical Office, Washington, D.C., will become manager of the Veterans Administration Hospital in Memphis, Tenn. He will succeed **Dr. Franklin C. Cassidy**, who is being transferred to the Office of the Area Medical Director at San Francisco.

Louis M. Peelyon has been named administrator of Pioneers' Memorial Hospital District, Brawley, Calif., which is scheduled for opening next October. He was formerly administrator of Lompoc Hospital District, Lompoc, Calif.

Edward R. Frye has resigned his position as administrator of H. F. Long Hospital, Inc., Statesville, N.C., to accept the appointment of administrator of the new Caldwell Memorial Hospital at Lenoir, N.C.

Charles T. Patterson, formerly administrative assistant to **Harold K. Wright** at the Methodist Hospital, Sioux City, Iowa, has been appointed superintendent of the new Buena Vista County Hospital, Storm Lake, Iowa.

Nicholas A. Herrig has resigned as business manager of Kankakee Clinic, Kankakee, Ill., to become administrator of Audrain Hospital, Mexico, Mo.

Howard Taylor is now assistant director of Niagara Falls Community Hospital, Niagara Falls, N.Y.

Lt. Col. Robert B. Lewy has been appointed commanding officer of the 427th General Hospital, a 1000 bed U.S. Army reserve unit which is sponsored by the University of Illinois College of Medicine.

Dr. Richard J. Graff has been transferred from the Peoria State Hospital to the superintendency of the new Gales-
(Continued on Page 178.)



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The Saftiflask can be *inverted* and *suspended* with just one hand. On the I.V. standard this unique bail holds the Saftiflask securely in an "ice-tong" grip.

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Available Everywhere Over 100 strategically located Cutter Hospital Suppliers reduces necessity of large stock in your hospital.

Volunteer Forum

Conducted by Raymond P. Sloan

FLOWER SERVICE EARNs AN ORCHID

for the Pink Ladies of Ellis Hospital

J. LAWRENCE MURRAY

Public Relations Director
Ellis Hospital
Schenectady, N.Y.

THE Volunteer Aides of Ellis Hospital, Schenectady, N.Y., has added another community group to its list of staunch supporters—the florists of that Mohawk Valley industrial community.

"Resolved by the Allied Florists of Schenectady County that this organization express to the 'Pink Ladies' of Ellis Hospital its sincere appreciation of the work being done by this group in handling flowers at the hospital.

"We understand that this group is unique in that it offers this type of service and we are grateful that it becomes our good fortune to profit thereby."

With these words the florists of Schenectady recently saluted the Volunteer Aides of Ellis Hospital for its years of service in distributing flowers sent to patients at the Schenectady institution.

"Pink Ladies" has become a familiar nickname for the volunteer aides be-

cause of the traditional pink dress they wear while on volunteer duty. This community service organization was 20 years old in February.

The volunteer aides organization is unique in its relationship to the hospital and to the community for it prides itself on being a service organization of more than 100 non-dues paying members. Social events and campaigns for funds are not in the objectives of this group, for by unselfish service alone do the "Pink Ladies" daily demonstrate their worth.

It is this spirit which moved the volunteer aides in 1942 to take over the entire distribution of flowers which arrive at the hospital from area florists.

The war was beginning to take nurses from the bedside at Ellis as in

other hospitals. The volunteer aides, who had been doing yeoman work in other services at the 400 bed institution, developed a plan to relieve the nurses of the nonprofessional chore of flower distribution.

For some years prior to this period the volunteers had conveyed the flowers from local florists to the various floors, at which point the nurses took over and brought the bouquets to specific patients.

The opportunity to expand this service was welcomed and a flower committee of the volunteer aides worked out this schedule:

Flowers destined for patients at the hospital are delivered to the institution by the florists on Tuesdays, Thursdays and Saturdays between 1 and 2:30 p.m. Florists may make deliveries at other times but must then take flowers directly to the patient.

On the specified days the volunteer aides man a flower reception desk at one of the hospital's rear entrances. There, from 35 to 75 bouquets are checked in on each delivery day. The florist delivers to the main desk; the volunteer aides complete the task.

The volunteers also accept flower deliveries on holidays by paying high school girls to do the work on several hours each holiday. School girls, who are members of the flower committee, also handle the program on Saturdays.

The volunteers keep a detailed record of each bouquet delivered to the



Two volunteers start the afternoon's work of distributing flowers. At left is Mrs. O. L. Wood, who has served on the flower committee for 15 years. With her is Mrs. J. C. Nutting.



"There is no better looking glass than an old friend"

More than 30 years of service to hospitals in capital fund campaigns is our mirror in which we see old friends inviting us again and again to return when the need for hospital expansion and modernization calls for new building funds

FORTY-THREE times since Pearl Harbor alone, we have been asked to go back to communities where hospitals were built or enlarged through our specialized practice. Thirty-one hospitals, our clients five, ten and even more than 25 years ago, retained us a second or third time; and 12 hospitals in cities where we had conducted programs for other hospitals engaged us for their building projects.

In recent years, from one-third to more than one-half of our practice has been devoted to hospitals in communities where our old friends know what our techniques accomplish. Most of our new clients choose us on the recommendation of the hospitals which we have served.

Three of our recent successes this year indicate the range of our objectives. A \$300,000 fund for the Manchester (Conn.) Memorial Hospital

was oversubscribed by \$55,000. In our two previous appeals for \$675,000 for this hospital contributions reached \$710,000.

The \$1,500,000 sought by the United Hospital Fund of Harrisburg, Pa., was oversubscribed, supplementing \$2,159,000 raised in our 1945 campaign for \$2,000,000 to enlarge Polyclinic Hospital and the Harrisburg Hospital.

A total of \$6,970,000 was contributed to the \$6,940,000 goal of the Rochester (N.Y.) Hospital Fund to expand five hospitals and build a new one.

Our record has led 143 hospitals, since Japan attacked Pearl Harbor, to entrust their programs to our management. These undertakings called for an aggregate of \$154,500,000. Contributions to these funds have passed the \$124,000,000 mark, although more than two dozen are still to be completed.

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flower reception desk. Before accepting the flowers from the florist the volunteer determines whether the patient is still at the hospital. If he is, the flowers are accepted and the following data go down in the book: patient's name, the date, name of the florist, time the flowers are received, patient's room number and volunteer's name.

The flowers then are placed on carts destined for the various floors and sections of the hospital. The flowers are taken to a utility room of the various floors, placed in vases, and then brought to the patients.

If, as happens occasionally, the patient has been discharged from the hospital and the volunteer desk has not been notified in time, the flowers are returned to the reception desk and a telephone call is made to the patient's family and/or the florist to determine the disposition.

The volunteers do not leave the flower desk until each bouquet is safely on its way or in the hands of the rightful recipient.

The volunteers accept the responsibility for any flowers delivered to them and are ready to pay for any that might be lost. This is infrequent, however, for the group now is completing a year without the loss of a single bouquet.

In a recent letter to the women who have served so faithfully, the florist organization said in part:

"Our only complaint is against the attempts by the Volunteer Aides to pay for bouquets on the rare occasions when they have been lost or misdirected at the hospital, and it is our aim to discourage these attempts."

Fifteen steady volunteers work on the organization's flower committee, one of six committees doing a particular type of volunteer work at Ellis Hospital. The faithfulness of these unsung workers is demonstrated by the record of Mrs. O. L. Wood who has served 15 years on the flower committee.

Dr. James E. Fish, director of Ellis Hospital, enthusiastically praises the faithfulness of the volunteer aides and their contribution to the care of the sick.

"The Volunteer Aides of Ellis Hospital has done an outstanding job as a working auxiliary and we at Ellis are proud to have this group associated with us in caring for the sick," declares Dr. Fish.

He points out that the efforts of the volunteers have in no small way helped

the hospital meet the problems of rising costs and a shortage of nurses.

Significant is the fact that in the last year 127 women have volunteered 6934 hours of work. Twenty-seven of these volunteers have worked more than 100 hours.

Leaders of the volunteer aides direct a program that raises no great amounts of money through card parties and other social events, that does not call for contributions of money or for payment of dues by hundreds of disinterested persons.

The "dues" of the Ellis hospital aides are paid in time and effort spent to help in the care of the sick.

The organization accumulates a small fund annually through the franchise the hospital grants it to operate a main floor newsstand. When this fund builds up to a certain point, the organization purchases some form of new equipment that is needed by the hospital.

On the latest such occasion, a year ago, the volunteer aides presented the hospital with a new operating table.

Which Half Is Private?

WITH its verve for lucid lingo, THE MODERN HOSPITAL may react to the following name-changing suggestions. It will probably suggest to me (and at some later date to its other readers) that hospital nomenclature is already confusing enough. "A practical nurse is a practical nurse" it will add, "and so is a ward." Anyway, here goes.

Which half of the patient is private? Shall we draw a precise line at the semi-mark from top to bottom? Is the exposed half public when the private half is safely covered from view? Can we determine the private semi by weight displacement? Or perhaps the room accommodation, price-wise, influences the degree of semi-privacy.

Semiprivate, semiprivate. The term has always bothered me. The doctor—and this is clearly set forth in his code of ethics—does not have one concept of medical relationship with his "private" patient, another which is "semi" and still another for his patient in the four or six bed "ward."

There are really a number of people who frankly prefer to be bedded down with one or two other patients in the same room. It isn't that they are semi-privately disposed—they just like company.

Here's my point. Let's call the "private" room a single room, or single accommodation. That's for the patient who's in a room by himself. His mind and anatomy are just as "unprivate" to just as many members of the medical, nursing and other hospital staff

as are those of his counterparts in the two, three or six bed room, and perhaps more "unprivate," numerically, to visitors.

Let's call the "semiprivate" room a companion room, or two-companion room or double room if you don't want to go all the way with me. I think "companion" is the descriptive designation. That's really what it is. And that's what many people think of when they seek hospital accommodations.

And here's my final plunge. "Ward" connotes guardianship, custody, even unwilling confinement. It implies indigency; (even at \$12 a day prepaid). Recently we have been trying to educate ourselves, hospital personnel, doctors and the consuming and supporting public, that there is no distinction in quality or quantity of medical and hospital care rendered to patients by room or service category. We are trying to convince ourselves that the patient receives the best of medical care when he is the focal point of the coordinated efforts of the medical and other professional personnel in the hospital, irrespective of his bed or room number. It is high time to take the stigma of "ward" from multiple patient bedrooms, and to give them the dignity they deserve through the use of another name.

My "wards" have become multiple companion rooms, or four-bed companion rooms for the more exacting.

Do you know where I can find a good private room cheap?—J. WALSH STULL, administrator, Memorial Hospital Association of Charleston, W. Va.



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REGIONAL BLOOD PROGRAM IS POPULAR

HERBERT BROWN, M.D.

Director
Regional Blood Bank
Rochester, N.Y.

THE Rochester Regional Blood Program began its operation on Jan. 12, 1948, and was destined to care for the total whole blood and plasma needs, and eventually all blood fractions, of the 12 counties in a western New York area which covers about 5000 square miles and is populated by slightly less than one million people. There are 43 hospitals in the region and the program meets the total needs of all of the private, municipal, county, state and federal institutions within its boundaries.

The program was planned initially in 1946 by the local hospital and medical groups under the sponsorship of the Rochester Council of Regional Hospitals which is supported by the Commonwealth Fund.

LOCAL MEDICAL SUPERVISION

After many conferences it was agreed to proceed with the project which received endorsement from hospitals and other groups and from the medical societies of all 12 counties. In the beginning, local medical supervision was assured and the 20 Red Cross chapters in the region were called upon to recruit donors as was done in World War II. Thus the general plan was in effect and ready to go prior to the decision of the American Red Cross to enter into a National Blood Program. Rochester, N.Y., was then chosen by the American Red Cross as the first of the regional centers to begin operation.

The record of the first two years of operation of this unit may provide some basic or comparative data for hospitals now participating, or contemplating participation, in a regional program.

In the first two years of the program's operation, 50,025 pints of blood were obtained from approximately 52,500 donors. These figures thus show that, per million population, about 25,000 pints of blood will be required from something under 30,000

donors. Rejects account for the difference. Fifty per cent of the blood came from the region itself and the other half from the city of Rochester and its surrounding towns. Each American Red Cross chapter in the region has assumed the burden of meeting its quota of donors.

No potential source has been disregarded—industry, religious groups, and, last but not least, the women at home. Eighty per cent of all donors came from large and small industries. The industrial operations are mobile for the bleeding unit goes to the factory and is set up in it. The donor is processed and back to his job in a little more than an hour in most instances, and all the companies have generously permitted their employees to make their blood donations on the company's time. It works for good company-employee relations and is regarded as a community duty.

The donations are all on a volunteer basis and no credit system is used. The blood is provided without charge to the recipient, but the hospital may make a \$7.50 charge for administration of each pint of blood. This charge has always been in effect and is needed to pay for the hospital storage facilities, extra equipment and personnel. It is comparable to the charge made to the surgical patient for the use of an operating room.

Blood, which becomes outdated, *i.e.* that which is not used within the 21 day period following its removal from a donor, is utilized by being turned into blood fractions. These are human plasma, human serum albumin, anti-hemophilic globulin, or fraction 1, immune serum globulin, fibrin film and fibrin foam. The majority of these fractions are available and will be available on an increased scale as various regional centers throughout the

country pool their outdated material. It should be pointed out that only by a cooperative program such as this can one stockpile large amounts of these materials which can be used not only for current medical and surgical problems but also for preparedness against disaster. The program is explained to the public by speakers, pamphlets, movies, posters, radio and newspaper publicity. Human interest stories are discreetly used and the increasing value of blood in medical and hospital care is described.

The plan has been enthusiastically supported by all 43 hospitals of the region and in only a few instances of emergency has it been necessary for some of the hospitals themselves to obtain a donor. This type of emergency is also handled by the central bank, for in such cases the names of previous donors are called upon and they can be taken directly to the hospital to provide the proper type of blood.

HELPFUL TO RURAL HOSPITALS

The program has been singularly helpful to the rural hospitals, many of which previously had great difficulty in providing adequate blood, but the second year of operation in this region showed an increase of about 20 per cent in the use of blood by all hospitals. There is generally a real and necessary increase in the use of blood, particularly in the field of surgery, and these increases do not necessarily mean that large amounts are being used simply because it is more readily available. New and extensive types of surgery are being done and will continue to be done simply because the availability of whole blood allows them to be accomplished. A rough rule of thumb is a need of 5 pints of blood per bed per year.

Perhaps the most conspicuous example of the value of a large bank of this nature is illustrated by the obstetrical case which has suffered a se-

in alcoholism...



7:15 P.M. Handwriting of a patient with delirium tremens, before Tolserol was administered.

7:40 P.M. Handwriting of same patient, twenty-five minutes after the oral administration of Tolserol.

Tolserol

Squibb Mephensin (3-o-toloxyl, 1-2-propanediol)

- to control tremor and quiet the patient
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- to reduce or eliminate the use of paraldehyde and barbiturates
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vere postpartum hemorrhage. In such instances it is not uncommon for more than a liter of blood to be lost in one or two minutes. Nothing can save such a patient except immediate whole blood replacement of the proper type. Every hospital bank, therefore, maintains a running supply and can get additional units from the central bank, or near-by depot, within about 30 minutes. In the county of Monroe, with its half a million population, no postpartum deaths have been reported as attributable to hemorrhage during

the last two years of the operation of this program.

It is felt that whenever possible the doctor should remind his patients, particularly those receiving blood, that they have a certain moral responsibility to see that the blood used is replaced. Those intimately concerned with the program feel that this should not be a harsh or stern appeal, but a general and continuing reminder that there is only one source for this material and that it must come voluntarily from human veins.

The Rochester regional blood program is only one of 30 such centers of the American Red Cross but it has proved a popular one from every standpoint. Citizens learn at first hand of its benefits and value and are willing to donate their blood in peace as in war. The most important aspect of all, however, is the existence of a coordinated community plan, which, in a time of national emergency, could be called upon at once to supply one of the most necessary agents of ment.

SMALL HOSPITALS as CENTERS OF MEDICAL EDUCATION

STAFF meetings bring together physicians whose experience lies entirely in the community the hospital is serving. In order to broaden their vision for an understanding of problems, the staff members should have a definite plan which brings to them the experience of others. They should be able to observe training and experience different from their own as applied to an analysis of their own specific problems. Therefore, in looking toward a teaching development, an active staff will have a well planned institute program whereby physicians from other communities visit the hospital for the purpose of making their experience and training available to the local physicians.

There are two ways that this can be done: in one instance the visiting physician will have a prepared paper discussing some of his own patients, the methods he used in studying them, and the therapy he employed; in another the visiting physician will be asked to see two or three or even four patients per day, both in the hospital and in the clinic, and to discuss these conditions with the local physicians on the basis of the physical examination which is made and such laboratory work as may be done. In the first instance, he is making available his experience in his own en-

JOHN T. MORRISON, M.D.

Area Medical Administrator
United Mine Workers of America
Welfare and Retirement Fund
Charleston, W.Va.

vironment; in the second, he is making the same experience applicable to the local environment. In order to distinguish it, the second form is called a consultative institute.

There are several variations of the consultative type of institute, and we will describe one of them held recently in a Southern hospital. This institute lasted for four days. The leader, an associate professor of medicine in a medical school, arrived at the hospital on Sunday evening, the day before the institute. On Monday morning some 10 or 12 staff members met him in the library of the hospital. One of their number had been delegated chairman for that day and was responsible for making arrangements for the patients to be seen. On this morning general rounds were conducted on one of the floors where every patient, medical and surgical alike, was seen by the visitor and examined by him. Two of them were selected for discussion. A more or less general history and physical examination were made on most of the patients seen, particular attention being given to the two selected for discussion so that the leader could begin his discussion and analysis of the

medical situation presented on a basis which he himself had established.

Immediately after the rounds the staff members adjourned to the library where the leader carefully analyzed the medical situation presented by the history and physical examination and suggested such laboratory and x-ray work as he might need to support his analysis. Where such x-ray work had already been done, it was presented by the attending physician as requested. In other cases where certain x-ray pictures had not yet been taken and certain laboratory work was still needed, arrangements were made for the reports on these to come to attention the following morning.

The clinical records of both patients were then presented as requested, and in both instances the analysis of the local physician was found to be similar to that of the visitor. Differences of opinion between the attending physician and the visitor as to the physical examination or history were discussed and different methods of physical examination were brought out which helped to clarify the situation.

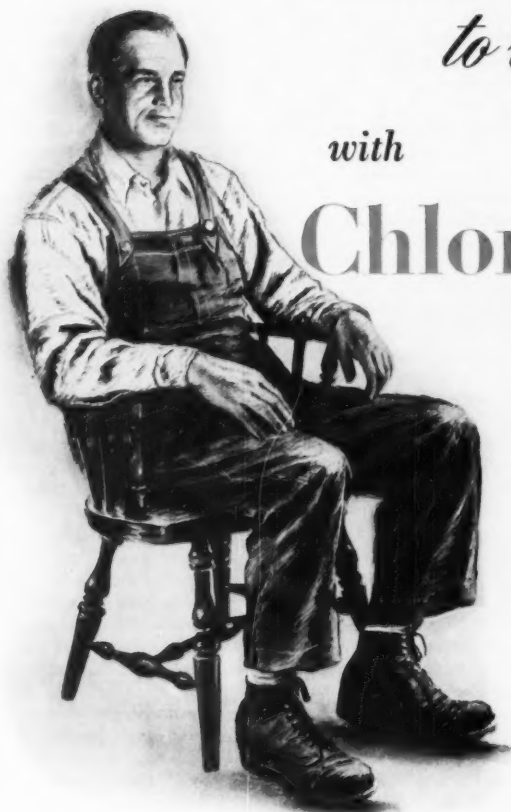
In the afternoon a clinic was held in the hospital assembly room to which patients from the offices of the various physicians were brought. Approximately six such patients were seen in the course of one afternoon, some representing conditions difficult to diagnose which the family physician desired to have discussed with particular

This is the second section of Dr. Morrison's article. The first appeared in the March issue of this magazine.

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The cost of medication, of course, is but one item in the total cost of illness, the greatest expense stemming from the length of incapacitation and consequent loss of working time. One distinct advantage of CHLOROMYCETIN therapy is its fundamental economy—quick clinical response, reduced morbidity, shortened convalescence and earlier return of the patient to his job.

Particularly dramatic results are now obtained in a disease such as typhoid fever, where the illness formerly ran its course for several weeks because of the lack of specific therapy. The lengthy hospitalization, special nursing care, the supportive measures during this prolonged period—all have contributed to increased costs. However, CHLOROMYCETIN changes this: the duration of illness is greatly reduced, deferment occurring within 2 to 3 days after treatment is begun. With control of the infection, general improvement is manifest and recovery is rapid.

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reference to the type of treatment. Others were more or less obscure conditions frequently encountered in general practice, and these provided an excellent opportunity for medical analysis in their specialty.

All present had an opportunity to observe the method of history taking and physical examination employed by the visitor in reaching his conclusion, and all had the opportunity to verify the physical findings. Such laboratory and x-ray work as was ready was presented and any which could not be completed that afternoon was presented the following afternoon. The patients of three or four physicians were discussed, and these had been arranged for through the chairman for that day. Nine or 10 physicians were in attendance including, of course, those whose patients were to be studied.

Throughout the institute the number present at these clinics remained about the same. The evening sessions started at 7:30. Here previous correspondence had established the staff's interest in a discussion of certain questions, and the leader presented a general résumé of the field under discussion. In the course of his discussion there was frequent opportunity to refer to the patients seen that morning and afternoon. The discussion the first evening was devoted to liver disease; this session was attended by approximately 20 physicians, several of whom were from nearby communities.

LOCAL EXPERIENCES DISCUSSED

The same pattern was followed throughout the four days of the institute. In almost all instances where partial x-ray and laboratory work had been performed, the patient in question was brought up for discussion a second time following the more nearly complete work-up. The sessions were enlivened by active reciting of local or other experience involving features similar to those of the case under discussion.

The physicians of this hospital had wanted a leader who would come to them prepared to give them the benefit of his training and experience as applied to their patients rather than to discuss his own clinical experience in his own community. Therefore, much discussion resulted because the local staff men were directly involved with the patients presented and analyzed; they were talking about situations which confronted them in their every-

day practice and through the medium of the institute were getting the value of another method of thinking, another source of experience, and other training as applied to their local circumstances. As staff members became more intimately acquainted with the leader, a true exchange of ideas followed. It is in this exchange of ideas that an institute is of the greatest value. It was as if the conditions of their practice were being duplicated on a stage by someone with a different training and experience.

There are many variations of this general pattern of a consultative institute. For example, one hospital which recently held its first institute decided to select two patients for each period of discussion who would represent a specific condition which they wanted discussed. Again, the experience and training of the leader were demonstrated in their application to patients and conditions encountered in local practice. Likewise, the methods of therapy which were discussed applied to specific situations with which the local physicians were all familiar and which they could understand. This institute extended only three days but followed the same general pattern of morning, afternoon and evening sessions, the morning and afternoon sessions being devoted to clinical case discussion.

As a variation, other hospitals have held one-day institutes so arranged that in the morning the visiting leader may see from two to five patients representing various disease conditions encountered in general practice. The afternoon sessions are given over to a discussion of the condition presented by the patients seen in the morning, and a few analogous cases are cited by the leader out of his own experience. This type of institute lends itself better to the specialties. For instance, in the morning a dermatologist, we will say, would see from 10 to 12 patients representing dermatological conditions seen in general practice. In the afternoon he would discuss with the staff the conditions presented and the types of treatment which he would institute under the circumstances in that community.

In the obstetrical specialty a two-day institute has usually seemed the best. Obstetrical patients from the hospital furnish the basis for the visitor's discussion, and several others are brought from the doctors' offices for examination. Prenatal experience is discussed

on the basis of individual patients. Pathological conditions are presented and discussed on the same basis.

In general, it has been the experience that these consultative institutes are a considerable improvement over the institute at which the leader presents a paper. They require, it is true, considerably more work on the part of the staff in preparing for such a program. The staff must be organized; the patients to be seen must be prepared as far as is possible, both psychologically and medically; the order of the program must be scheduled carefully, and the additional time of the visiting consultant must be planned with care so that all physicians will have an opportunity to work with him. These institutes also require more alertness on the part of the visiting clinician, who must make a complete analysis of the conditions that are presented. There are times when a give-and-take situation develops and individual experience is related in detail.

PREPARE FOR THE FUTURE

Such programs as institutes prepare a staff for its future teaching activities. In fact, with the development of liaison with a large center or a university medical school, the resident and intern committee from the larger institution might informally take the rôle of the institute leader. The reverse should be true when physicians from the small hospital visit the large center and participate in ward rounds or clinic activities. This pattern is transferable directly down to the teaching of residents and interns in the small hospital as ward rounds develop.

Postgraduate work for the practicing physician in a medical school center is a rather difficult problem. The irregular times when physicians in practice are able to get away for such postgraduate work, the limited period which they have to spend in intramural teaching, and the difficulty of arranging for a course which will be of value are a few of the questions to be raised by a medical school attempting to meet the needs of the community it serves.

The postgraduate work of the practicing physician takes him away from his practice and, therefore, his income ceases. Two methods have been devised to assist in meeting this problem. One method calls for a stipend subsidy to be made available to the physician which, to a limited extent, compensates him for the loss of income while away from his practice. This method has

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been moderately successful and has received favorable comment from the physicians able to avail themselves of it. It seems, however, to be limited in its application to possibly one and maybe two periods of study. It does enable the physician, however, to undertake a longer period of study than he may feel able to spend from his own financial standpoint or his feeling of responsibility for his patients.

The second method is that of supplying a sort of resident physician as a locum tenens for the physician undertaking the postgraduate work. In this way the absent physician is assured of some of his income and, more than that, is assured that the medical needs of the patients he normally serves are covered. The first method calls for a basic fund of money for its support; the second requires an organization, usually of the postgraduate center, with additional resident physicians capable of undertaking a locum tenens that is satisfactory to the practicing physician.

It is conceivable that the several agencies having a stake in a continuing program of postgraduate study might combine to establish a fund to support this activity and the organization to supply locum tenens as may be indicated, especially if there is a community hospital in the picture. The community itself has a stake and could through the hospital administration organization establish a postgraduate fund. The medical society has a stake in this activity also. And by no means least, the practicing physician has a stake. The medical school or a larger affiliated hospital is the organization which can supply residents for locum tenens, and a community hospital affiliated with a medical school has reason to discuss this feature with the school to which it is affiliated. A cooperative arrangement of advantage to all parties is worth investigating.

The time during which the postgraduate work is undertaken is important. Most physicians feel that they are unable to spend longer than two weeks. This period barely permits them to become acclimated to the atmosphere of the school and to begin to get the information that will be of value in their practice. The optimum lies between three and four months, which permits the development of a close association with teachers that furthers an exchange of ideas. It is not inconceivable either that the future will see a planned organization for the purpose of developing a closer association between the

postgraduates and medical students for the purpose of giving instruction by informal methods in the comprehensive type of medical service the general practitioner must give.

The average physician receives his impressions largely through contact with patients. A busy practice has not left much time for him to read extensively although he may have kept up with the current medical literature. Institutes held at the hospital usually show that the most value is obtained from personal association with another physician over a patient. Therefore, the postgraduate work organized by the university which visualizes a large amount of didactic lecturing is of considerably less value than is the course which provides for the intimate contact between the attending physician and the student physician so that an exchange of ideas over a specific medical problem being presented by a specific patient can be effected. This is the most difficult type of work for the medical school to plan in that it cuts across a considerable amount of its day-to-day work, which is largely devoted to the teaching of medical students, interns and residents, who are in an entirely different relationship to the teaching physician than is the visiting general practitioner.

Postgraduate work is an integral part of the plan of the staff of a community hospital. It is one that will need to be coordinated with the medical school that serves the community in which the small hospital is located.

In summary, it may be said that the future of the small community hospitals lies in the direction of developing more and better general practitioners. Lay leaders in the community represented on the board of trustees have a stake in this development that is equal to that of the medical profession. Their combined efforts, therefore, might be devoted to the realization of the ideal of medical staff development of an educational type of organization, the establishment of a connection with a larger teaching hospital or a medical school, and a plan for the continuing exchange of information through medical students, interns, residents, institutes and postgraduate work. Teaching and learning begin wherever there is a patient in environmental difficulty and trained minds to study and meet such difficulties, and as a rule more is learned by meeting the environmental difficulties at their source.

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A pathologist proposes

"SHARE THE SERVICES"

plan for small hospitals

LAWRENCE PARSONS, M.D.

St. Mary's Hospital, Reno, Nev.

NOW that the full value of laboratory medicine is so generally recognized, even the small hospital must have facilities for such work. One institution can hardly furnish sufficient surgical, necropsy and clinical material to justify the services of a full-time pathologist, who needs quantity and variety to enable him to grow in his specialty. A pathologist is happy when he has a large volume of material to examine. This is attained by serving several small hospitals. No progressive pathologist would be willing to devote his full time to a single small institution unless perhaps he did a great deal of research. It would be a sort of scientific suicide for him not to have enough material.

The sharing of the services of a pathologist by a number of small hospitals in the same or adjoining communities is widely practiced today. Not only is it economically sound but also it enables them to have a consultant whose practice is large enough to keep him abreast with medical progress.

Whenever it is possible, it is best for the pathologist to make daily visits to the hospitals he serves. He should time them so as to consult with the technicians while they are on duty. Occasionally this may be impossible because of time-consuming necropsies or other work. He may then have to make his visit after closing hours in order to examine that day's surgical specimens, and once in a while go the following day.

While tissue specimens can be delivered to the central laboratory, I have found that frequent visits with the technicians are an important part of my work. They not only save interesting material for me to see but also ask numerous questions, a most healthy sign. While I recognize medical technologists as the backbone

of the laboratory, I feel they ought not be left alone in their work. We, the pathologist and the technicians, make the team that pulls together.

Of course, tissue specimens properly preserved can be mailed to the pathologist and quite satisfactory service can be rendered. Surgeons gradually learn that we are not detectives and that a brief history of the case is often most helpful to us. The telephone is indispensable in many instances, particularly when a prompt diagnosis is necessary. I have telephoned back a rapid frozen section diagnosis and spared a patient 75 miles away from a radical mastectomy by having the tumor, removed under local anesthesia, brought in by automobile to my laboratory.

FULL-TIME TISSUE TECHNICIAN

The quality of tissue diagnosis is no better than that of the histologic sections. We have all had the experience of being unable to render a diagnosis from a tissue section because of poor staining and other factors. A certain uniformity of quality in slides is best obtained by having them prepared in one central laboratory. When they are made as a part-time chore in several places by several technicians, they usually suffer as a consequence. One full-time tissue technician can prepare slides for a number of small hospitals. In my visits to various parts of the country, I find that this is a common practice among pathologists.

The preparation of sections of a high quality requires a specifically trained person. Men, as well as women, are often highly successful in this field. Tissue technic requires a broad knowledge of methods. First-class tissue technicians are harder to find than are those well qualified in general laboratory work. Owing to the fact that many of them are not trained in other branches of laboratory technic, they are commonly paid less than

their fellow workers. This is a serious mistake and a short-sighted policy. Many of them are artists in the truest sense.

There is a serious shortage of well trained medical technologists. Adequate training in schools approved by the Council on Medical Education and Hospitals of the American Medical Association requires a minimum of two years of college work plus one year of special hospital laboratory training before the graduate is eligible to take the national examinations given by the American Society of Clinical Pathologists. I know of no quicker way to train technicians satisfactorily. It takes time and work on the part of the pathologist and his technical staff but the results are justified.

Most doctors taking a residency in pathology do so for a year or two only without intending to specialize in that field. They take some training in it only to continue in surgery, internal medicine or radiology, all of which are financially more attractive. Pathology, like basic science in general, has never appealed to many young doctors. It is a branch of medicine that is inherently appealing to the few who are studious by nature. With the exception of internal medicine, I know of no other specialty which requires so much continued hard study to keep up with it. The fact that for years it has been generally a poorly paid specialty has increased its unattractiveness. By its fundamental importance in medicine, the specialty of pathology, however, has come to stay. Medical technologists, lacking the training and perspective of physicians, can never replace the pathologist, particularly in the field of tissue diagnosis and the correct interpretation of many laboratory tests.

If pathology continues as a medical specialty outside the confines of teaching positions in medical schools, there must be a reasonable financial reward. The practice now in vogue of private hospitals being able to hire a pathologist on a full-time salary basis will have to be modified considerably, in my opinion. I wish to make it clear at this point that I am merely giving my own personal opinion and that this entire discussion is not to be construed as reflecting any official opinion of any organization of pathologists.

A pathologist is a consultant, so far as his own personal services to the patient are concerned, and he should be so considered. He should bill the

Condensed from a paper presented at the American Hospital Association meeting, 1947.

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1. Watts & Ruthberg: *Ann. Int. Med.*, 29:1104, Dec. 1948
2. Henderson, V. E.: *Canad. M. A. J.*, 35:636-637, 1936
3. Gunther, Lewis: *U. S. Nav. Med. Bull.*, 44:390, 1945

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patient privately for his diagnostic tissue work. If the laboratory and its staff of technicians are maintained by the hospital, he should share in the net profit derived therefrom for his supervisory work.

The best plan is for the pathologist either to rent the laboratory space from the hospital or to pay it a percentage of the gross collections and then equip and staff it himself. For example, I own my equipment in one hospital, staff the laboratory and pay the hospital a percentage of the gross collections in lieu of a fixed

monthly rental charge. I have found that the entire receipts from my hospital laboratory just about pay for all of my professional overhead expense. This includes the percentage retained by the hospital, rent on a downtown laboratory, all salaries, equipment, books, medical dues, medical trips and other generally recognized expenses of a physician. My net income is derived from salaries from tax supported hospitals, private laboratory work done in both the downtown and hospital laboratory, coroner's work, court appearances, and so on.

From the standpoint of hospitals, so far as continuous work coverage is concerned, as well as from that of the pathologist, a partnership of two or more is highly desirable. A pathologist particularly needs to get away from his work quite frequently to visit with others and someone is needed to cover the work while he is away. This is a common practice and it should be encouraged more. I have made many visits and have brought home many ideas. It is not good for a man to work alone year in and year out. Pathologists, being fundamentally scientists at heart and frequently in actuality, are not an avaricious group and if their specialty will be made more attractive financially, much good will result.

Why should a pathologist *not* be employed by a private hospital on a full-time salary?

If a hospital has a group of physicians as a closed staff unit and if the surgeons, internists, anesthesiologists and other staff members are *all* on a salary basis, then, of course, the pathologist should be on a salary too. But if he renders consultation service in tissue diagnosis, hematology, bedside consultation with staff members on their private patients, and other personally performed diagnostic services, as most of us do, he should render a private statement to the patient in the same manner as does any other consultant.

Pathology *is* the practice of medicine. Furthermore, a pathologist, in order to be able to afford the necessary expense incident to his specialty, must have an income comparable to that of at least some of the other specialties. Besides doing consultation work as mentioned, he also conducts clinico-pathologic conferences, performs necropsies and directs the technical work of the laboratory. All this requires time and energy on his part and should be compensated. I believe that this phase of his activities should be performed on a profit-sharing basis with the hospital rather than on the level of a salaried employee. When he has a financial interest in his department the hospital is bound to profit by it. What I have said here does not apply to a fixed salary basis of work in tax-supported institutions. I should like to close by saying that any patient who cannot afford to pay the pathologist even a reduced fee should receive such service without pay. After all, a pathologist *is* a doctor!

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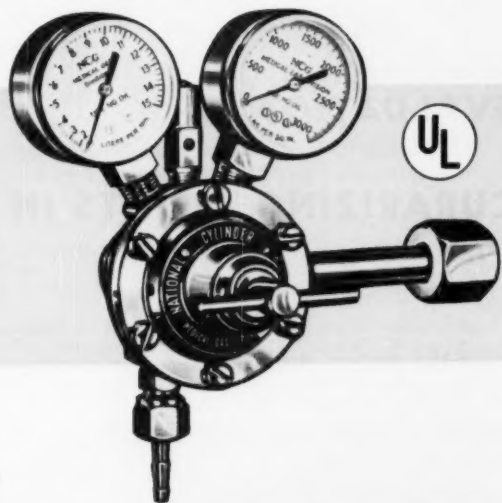


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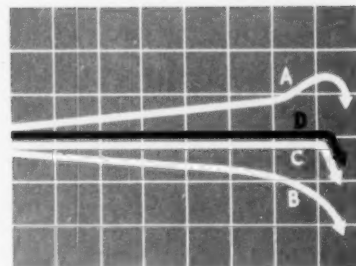


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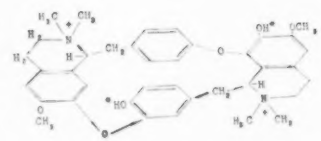
EVALUATION OF CURARIZING AGENTS IN MAN

CURARE, the South American arrow poison, is a brew concocted with ritual mystery from a variety of plants by the witch doctor of certain tribes. The natives dip their arrow points into the viscous preparation and small animals, wounded by the arrow, become paralyzed and fall prey to the hunter. Desiccated curare is a brittle brown substance. Its unique pharmacological action was discovered 100 years ago by Claude Bernard and his contemporaries, who stated that curare causes paralysis of the voluntary muscles by interrupting the transmission of nerve impulses at the neuromyal junction. The muscle, although no longer responding to stimulation of its motor nerve, remains capable of contraction if its fibers are stimulated directly.

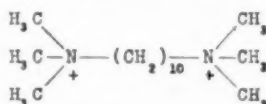
Attempts to introduce curare into therapy met with little success as long as no reliable purified preparation was available. With the isolation of d-tubocurarine in pure form and the elucidation of its structure, curarizing agents have become available, which have secured for themselves a definite place in medicine; particularly in anesthesia and in neuropsychiatry.¹

CHEMISTRY AND MODE OF ACTION

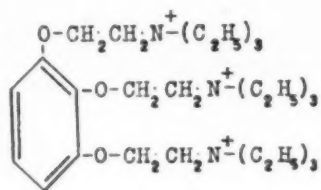
d-Tubocurarine (dTC) and dimethyl d-tubocurarine (dimdTC) are natural alkaloids obtained from the bark of South American vines (mainly *Chondodendron*). Two synthetic compounds, decamethylene-bis (trimethylammonium) (C10)² and Flaxedil³ have also been introduced into therapy.



d-Tubocurarine
In dimethyl d-tubocurarine, CH₃ replaces H in the starred positions.



Decamethylene-bis(trimethylammonium) (C10)



Flaxedil.

The specific action of these compounds on the neuromyal junction ("curarization") is probably related to the presence of quaternary-nitrogen atoms in their molecular structure. In proper dosages these agents paralyze skeletal muscles of the facial and neck region first, and then the larger muscles of the trunk and the extremities before the diaphragm becomes paralyzed. Larger doses will paralyze the diaphragm also and cause death by asphyxiation. The margin of safety of

all curarizing agents is small, and none should be given without provision for effective artificial respiration. Although the mode of action (block at the neuromyal junction) of these agents is the same in animals and man, the potency, duration of action, and relative involvement of various muscle groups differ remarkably from species to species.

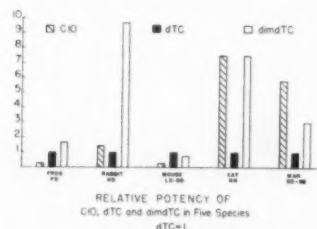


Figure 1.

Figure 1 demonstrates the wide variation in potency of three curarizing agents in various species; no satisfactory test animal is known in which the potency as well as the muscular effects of a drug are sufficiently similar to those in man to permit safe conclusions regarding therapeutic usefulness.

EVALUATION IN MAN

Thus, agents intended for curarizing effects in therapy can be accurately evaluated only on man himself by quantitative observations unobscured by the effects of an anesthetic or any other drug. More than 150 experiments were performed on four normal male volunteers ranging in age from 22 to 36 years and in weight from 150 to 180 pounds.⁴⁻⁶⁻⁸ The subjects, in a supine position, rebreathed pure oxygen through a mouthpiece. The circuit contained also a recording spirometer. A dynamometer, calibrated in kilograms, was used to measure the strength of the grip of the subject's left hand. Blood pressure and pulse were measured at frequent intervals. Ophthalmological observations, electrocardiograms and electroencephalograms were also obtained.

After a control period to allow measurements to assume constant values, the curarizing drug was injected intravenously over a 90 second interval. Grip strength, vital capacity and other observations were recorded frequently at appropriate time intervals during the course of the experiment. Communication with the subject was maintained by prearranged signals. An intubation kit, oxygen mask and bag were kept in readiness for administra-

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tests demonstrate that convenient "DYSEPT"—with 5% hexachlorophene to the anhydrous soap content—is both bactericidal and bacteriostatic with continuous daily use. Charts show percentage reduction.

• • • • •

CHART No. 1. Percentage reduction in resident bacteria on hands with continuous daily use of undiluted "DYSEPT" for 4 consecutive days. Tests actually ran over 5-day period. "Zero" days represents bacterial population before use of "DYSEPT."

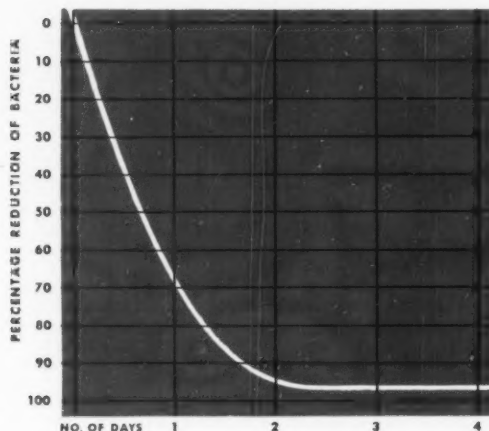
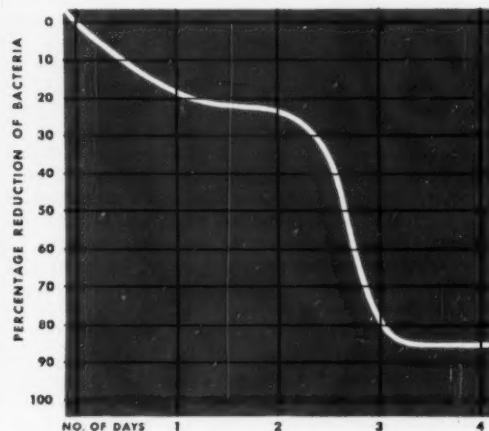


CHART No. 2. Percentage reduction in resident bacteria on hands with continuous daily use of "DYSEPT" diluted 1:1 with water for 4 consecutive days. Again, tests actually ran over 5-day period. "Zero" days represents bacterial population before use of "DYSEPT."



NOTE THESE FACTS ABOUT THE USE OF "DYSEPT"

"DYSEPT," containing 1% hexachlorophene to the total volume, leaves an invisible film not removed by rinsing which, with application one to three times daily for at least five days a week, reduces bacterial skin flora to about 5% of the usual amount and maintains that level. It has been found to reduce surgical scrub-up contact time with daily use. "DYSEPT" is non-toxic and non-irritating, and acts effectively even when diluted with water. A clinical brochure, with laboratory reports, suggestions for using and other technical data, may be obtained by mailing the coupon. "DYSEPT" is available through all Davies-Young distributors.

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tion of positive pressure insufflation in the event of acute respiratory embarrassment but were never needed.

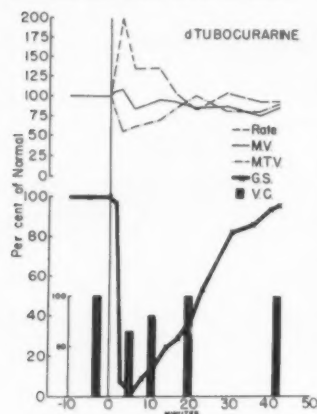


Fig. 2. Effect of 9.45 mgm. dTC in a subject of 70 Kg. All changes in per cent of control values: Rate=respiratory; MV=resp. minute volume; MTV=mean tidal volume; GS=grip strength; VC=vital capacity.

Figure 2 represents a typical experiment with dTC showing relative responses of grip strength, respiration, blood pressure and pulse and their duration. Forty-five seconds after the beginning of the injection, heaviness of the eyelids and transitory diplopia were perceived. At the completion of the injection, diplopia became fixed, and could be noticed only when the subject's eyelids were raised by the operator. As curarization proceeded, it seemed to the subject as if the facial muscles, the muscles of the neck and back, and the muscles of the extremities became relaxed in about that order. Simultaneously with the paralysis of the pharynx and the jaw muscles, inability of the subject to swallow occurred. This effect was similar with all drugs but was most marked when C10 was given. On the other hand, paralysis of the jaw muscles alone seemed to be most pronounced with dTC causing difficulty in holding the mouth piece in place. C10 differed from other agents in that the onset of paralysis was often accompanied by muscle twitches of a fasciculatory type.

POTENCY

The evaluation of the three curarizing agents shows that they differ characteristically and significantly in many respects (table 1).

Measured by the dose necessary to decrease grip strength by 95 per cent in a 70 kgm. man, C10 (2.2 mgm.) is

Table 1—Evaluation of Three Curarizing Agents

	Potency mgm.	Duration min.	Vital Capacity % Decrease	"Coefficient of Safety"
dTC chloride	9.45 \pm .8	26.8 \pm 7.1	31.3 \pm 16.3	1.48 \pm .48
dimdTC iodide	3.98 \pm .2	22.2 \pm 2.4	16.0 \pm 11.7	2.99 \pm 1.2
C10 bromide	2.24 \pm .4	20.1 \pm 1.3	61.0 \pm 2.3	.86 \pm .07

more potent than is dimdTC (4 mgm.) or dTC (9.5 mgm.). Flaxedil is about 20 times less potent than C10. As indicated by the standard deviations, responses to C10 showed greater variations and were less predictable than were the responses to the natural alkaloids.

EFFECT ON RESPIRATION

Measured by the per cent decrease in vital capacity when grip strength was depressed 95 per cent, C10 depressed respiration much more than did any other agent. In contrast to its "respiration sparing" effect, observed in cats and monkeys, it depresses the vital capacity in man to such an extent that adequate paralysis of the hand grip cannot be obtained without decreasing the vital capacity seriously (61 per cent). On the contrary, dimdTC, in equipotent doses, causes only slight diminution of vital capacity (16 per cent). Flaxedil resembles dimdTC in that it affects vital capacity much less than does C10. Once paralysis began in the muscles of the forearm or in the respiratory muscle, it proceeded at an equal rate in both muscle groups. The characteristic differences among the curarizing agents in depressing respiration are, thus, due to the differences in the threshold of the respiratory muscles to the various agents.

A "coefficient of safety" has been calculated as the ratio of the dose which depresses vital capacity 50 per cent (thus interfering seriously with gas exchange) to the dose which depresses grip strength 95 per cent (corresponding to a minimum degree of relaxation desirable for surgery). This coefficient is significantly lower for C10 than for dimdTC and dTC.

DURATION

The duration of action as measured by the time for 75 per cent recovery of grip strength differs significantly among the three agents. C10 has the shortest duration (usually less than 20 minutes), dimdTC has intermediate duration (21 to 26 minutes), and dTC

has the longest duration of effect (generally 27 minutes or longer).

With the doses used, no consistent changes were noted in the blood pressure or pulse rate that could not be attributed to the psychic state of the subjects and no alterations were noted in either the electrocardiogram or the electroencephalogram. Pain thresholds were not affected by any of the drugs.

REPEATED ADMINISTRATION

Cumulative effects of dTC and dimdTC were observed when these drugs were readministered after all measurable effects of the first dose had disappeared. After a 45 minute interval, injection of one-half of the initial dose produced effects which were about equal to the effects of the first dose (fig. 3).

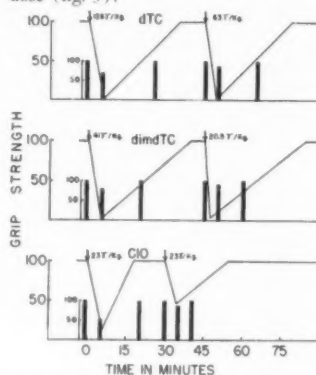
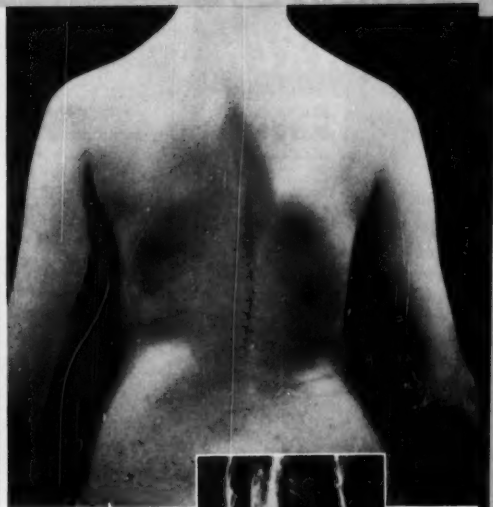


Fig. 3. Effect of repeated administration of curarizing agents on grip strength (solid line) and vital capacity (bars) expressed in per cent of controls.

It may be concluded that at this time after apparent recovery, about half the amount of injected dTC or dimdTC still remained in an active form in the organism. No cumulative effects were observed in man with C10. Administration of a second and equal dose 30 minutes after the first injection consistently produced a significantly lesser response than did the first dose. Thus, tachyphylaxis to C10 occurs in man, a characteristic not observed in animals.

(Continued on Page 110.)



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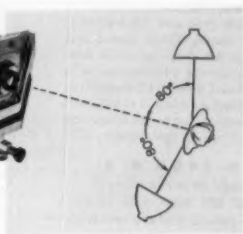
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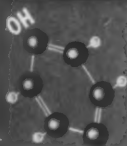
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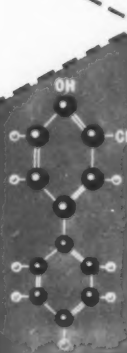
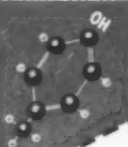


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ANTAGONISM

Pretreatment with neostigmine (0.75 mgm.) produced a significant diminution in the severity and duration of the effects of dTC (table 2).

Table 2—
Average Decrease in Grip Strength

	Control	After Neostigmine	After C5	After dTC
dTC	94.5%	57.7%
C 10	90.5%	90.4%	0%

The effects of dTC on grip strength were, however, by no means abolished and were comparable to those otherwise obtained with about 60 per cent of the dose used.

In contrast to dTC, C10 is not antagonized by neostigmine. It has been claimed that pentamethylene-bis (trimethylammonium iodide) (C5), a close chemical analog of C10, has an antagonistic effect upon the action of C10 in animals and in man. Although it may antagonize the effects of C10 in some animals (rabbit, cat), it was found that pretreatment with 50 mgm. of C5 failed to diminish the effectiveness of C10 in unanesthetized subjects. The effects of C10 were completely abolished, however, when it was given after recovery from curarization with dTC. It has also been noted during surgical anesthesia, that on occasion, an otherwise effective dose of C10 is inadequate for reinforcement of muscular relaxation if given after the administration of dTC.

CONCLUSIONS AND CLINICAL IMPLICATIONS

The differentiation of the curarizing agents has been made entirely on their effects on the skeletal musculature and the persistence of these effects. Doses which paralyze skeletal muscle adequately for abdominal surgery have no consistent effects on structures innervated by autonomic nerves, on the central nervous system, on pain thresholds, or on consciousness and cerebration. No observations indicating release of histamine were noted in any of the subjects, although dTC has been shown to release histamine from skeletal muscle in a greater measure than C10 does. In the dosage compatible with experiments on volunteers, no untoward side-effects were observed with any of the agents. Nevertheless, the differentiation among the drugs as obtained in experiments on unanesthetized volun-

teers is essential to a critical evaluation of these agents for therapeutic use.

A summary of the results allows conclusions which must be considered in the choice and rational use of any of these agents.

1. In potency, as determined by equal effects on grip strength, C10 surpasses all other agents.

2. C10 shows a greater variability in response than either dTC or dimdTC.

3. The threshold of the respiratory muscles to the paralyzing effects is significantly different for each drug. It is lowest to C10 and highest to dimdTC and Flaxedil. The "coefficient of safety" is lowest with C10 and highest with dimdTC.

4. Duration of action is shortest with C10, intermediate with dimdTC and longest for dTC.

5. Repeated doses of dTC and dimdTC are cumulative when given at intervals of 45 minutes, even after recovery from measurable effects. Repeated doses of C10 are not cumulative, but produce, on the contrary, a lesser response.

6. Further studies on the effects of repeated doses of C10 are indicated since, following such administration, profound respiratory depression for many hours has been reported in anesthetized patients.

7. Neostigmine mitigates but does not completely abolish the effects of a subsequent injection of dTC. No effective antidote to C10 is available.

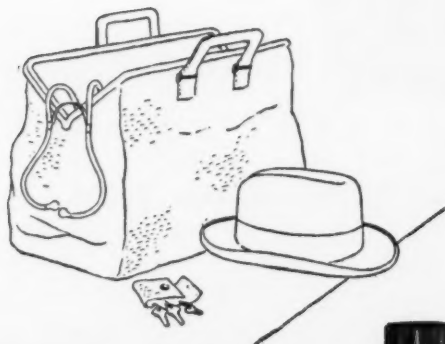
8. Pretreatment with dTC diminishes greatly the curarizing effects of a subsequent injection of C10.

9. In contrast to dTC, C10 does not act synergistically with ether on the neuromyal junction.

10. Differences between dTC and C10, as shown in antagonism to neostigmine and synergism with ether, indicate that the mode of action of these agents at the neuromyal junction is not identical.—K. R. UNNA, E. W. PELIKAN, D. W. MACFARLANE, R. J. CAZORT, M. S. SADOVE, J. T. NELSON.

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MAKE CREAM SOUPS THE MAIN DISH

MARIETTA EICHELBERGER

Director
Home Economics and
Nutrition Service
Evaporated Milk Association
Chicago

THE French have always been famous for their soup. They have a way of keeping the soup pot simmering on the back of the stove ready to receive bits of meat trimmings and bones, and broth left from cooking meat and vegetables. While the French soups had a savor all their own, oftener than not they left much to be desired in nutritive values. No doubt many vitamins were destroyed in this long cooking process, and other values were lacking.

In this country, the old-fashioned soup kettle has long since disappeared and has been replaced by more modern methods of making soup. There are countless varieties of the ready-made ones available, to say nothing of the vast number the home-maker or the dietitian concocts every day.

FALL INTO TWO CLASSES

Soups can be so good or they can be so poor—depending upon the ingenuity and food appreciation of the person who makes the soup. By and large, the soups most used fall into two classes: clear and cream. These have a vast number of possibilities, the cream soups especially. They may take the form of bisques, chowders, and the like. They may be thick or thin and still contain much of the milk each individual needs.

For the most part, soups are usually served as an appetizer or at the beginning of the meal—either very hot or very cold. However, cream soups are more than an appetizer. They are rich in food values. They give substance to the meal and can serve as the main part of the meal. In fact, they serve as excellent carriers of other highly nutritious foods, such as meat and vegetables, combined with the milk or cream. Too, because they contain both milk and butter in addition to the vegetables or meat or fish, that give them their characteristic flavor, they

are a valuable way of putting more milk, milk products, and other essential foods into the diets of both children and adults. As a main dish, then, the cream soups are the soups to be used. They make a light meal more attractive and satisfying, as well as more nourishing.

The creaminess of the cream soup depends in part upon the kind of milk used in making the basic sauce.

Evaporated milk gives cream soups a unique creaminess. Because it is milk with half the water removed, more milk can be used in less volume. Thus, more milk nutriment can be added. Then, evaporated milk is homogenized. This means that the large fat globules in the original milk have been broken by high pressure into tiny particles which are dispersed throughout the liquid. As a result, the milk, and hence the cream soup made with evaporated milk, has an unsurpassed smoothness.

Another advantage in using evaporated milk in cream soups is that vegetable liquors and meat or fish broth can be used in the soup without making it too thin. That is, the milk as it pours from the can is combined with these liquors instead of water. Thus, nutritive values as well as flavors can be saved and a creamier, better cream soup can be had.

In addition, extra nutritive values are added through evaporated milk because all evaporated milk is now fortified with 400 U.S.P. units of vitamin D per pint or reconstituted quart. Inasmuch as the diet of children and adults is likely to be low in vitamin D, the use of evaporated milk with vitamin D added for making cream soups supplements the diet with this important vitamin.

Still another important advantage in using evaporated milk is that it does not curdle as easily when mixed with acid vegetables as does other milk. Even cream of tomato soup stands up much better when made with evaporated milk. However, the ideal way of combining the milk with any acid vegetable, such as tomatoes, is to heat the two separately and then combine just before serving. Pouring the tomato juice into the milk gives the smoother soup. Then, if the soup is handled so it does curdle, the curds of evaporated milk are much smaller than are those from other forms of milk; thus, the attractiveness of the soup is less affected.

COLD SOUP IS GOOD, TOO

While we have implied that cream soups are served hot—and very hot—there are cream soups that are excellent served very cold. Chilled cucumber or crème vichyssoise suggests a crisp coolness for the hottest of summer days.

Oyster stew made with evaporated milk has no equal. Such a stew has a smoothness, a creaminess, a flavor all its own; and although it is creamy, yet it contains fewer calories than stew made with fresh cream. With a dash of sherry, it is delicious, easy and economical to make.

Cream of tomato soup, mushroom, leek and potato, even spinach with a bit of curry, the borsches, all are just that much more acceptable when they have flavor, texture and color.

The acceptability of a cream soup also may depend upon its texture. Children like a thicker soup; adults usually like it thinner. The children like the vegetables finely puréed; the adults like them chopped.

Nothing so detracts from a cream soup as does lumpiness. It is therefore essential that the method of combining the basic sauce with other ingredients must be undertaken in such a way



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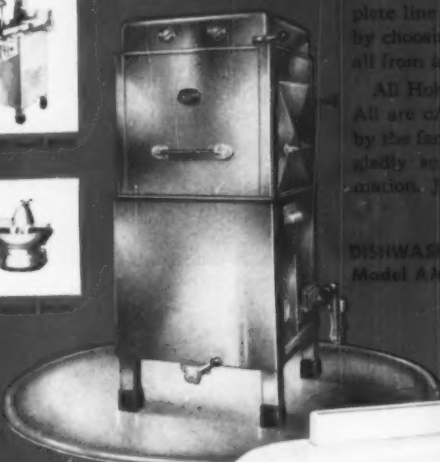
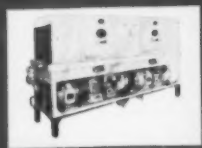
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as to produce a smooth sauce free of lumps. Fine bread crumbs instead of flour may be used as the thickening agent without producing lumpiness. After the basic smooth sauce is made, the sieved or chopped vegetables, meat or fish and sometimes fruit may be added. With such vegetables as potatoes, green peas and the like, thickening may not be needed. That is, the evaporated milk as it pours from the can may provide sufficient thickening for some soups which may be served either hot or cold.

SOUP ACCOMPANIMENTS

The old saying that "variety is the spice of life" is readily adaptable to soup accompaniments. One way to have variety with soups is to use dry crisp foods with the liquid. Thus, crisp crackers of all kinds and flavors, especially the whole grain and shredded wafers, help make soups more interesting—especially for those who like

to defy Dame Custom and crumble their crackers into their soup. Toast strips, melba toast and croutons may have a sprinkling of cheese added; these give crunchiness and flavor. Tiny toasted sandwiches or cheese straws and potato chips add desirable solidness and a tangy flavor to the bland soup.

Relishes, such as celery, radishes and olives, furnish a contrast. Their crisp cool texture increases the enjoyment of both soup and relish.

Garnishes which are often neglected also may add to the attractiveness and appetizing value of soup. Whatever the garnish used, it should be put on just before the soup is served. In this way, it will be at its freshest and best when eaten.

The garnish may be simple—as a dash of paprika, or some herb, or just fine crisp croutons or egg drops floating on the bowl; or it may be a sprinkling of chopped parsley, celery

leaves, some gratings of raw carrots, or a few kernels of fluffy popcorn or one of the puffed cereals.

A spoonful of whipped evaporated milk gives the soup an interesting richness. Of course, the evaporated milk must be icy cold for whipping. If a soured topping is preferred, fold lemon juice or vinegar into the whipped milk. This topping with acid added will stand up longer than will the plain whipped milk.

GIVE SUBSTANCE TO MEALS

Cream soups at their best make a main dish that is interesting, attractive and good to eat. They give substance to meals. Use them oftener as the main dish of the meal. Cream soups made with evaporated milk have all of these advantages plus creaminess and a high nutritive value.

The following suggestions will help in making cream soups a main part of the meal.

CREAM OF TOMATO SOUP (10½ quarts, 56 three-fourth cup servings)

2 No. 10 cans tomatoes (6½ qt.)	1 tsp. cloves
1 small bunch parsley	1 onion, sliced
1 tsp. thyme	5 tbsp. sugar
2½ bay leaves	4¼ qt. thin white sauce
1 tbsp. whole peppers	

Boil tomatoes with all the seasonings 5 minutes, then rub through a sieve. There should be 5¾ quarts liquid and pulp. If not, add water. Pour tomato mixture slowly into hot white sauce when ready to serve, stirring to blend well. If white sauce is made from evaporated milk and an equal quantity of chicken or meat broth, a delicious variation results.

THIN WHITE SAUCE (1 gallon)

¾ c. butter	¼ tsp. pepper
1 c. flour	½ gal. boiling water or broth
1½ tbsp. salt	½ gal. evaporated milk

Melt butter. Add flour, salt and pepper, and mix thoroughly. Do not allow flour to brown. Add water and boil until smooth and thick, stirring constantly. Add milk and continue cooking until thickened, about 10 minutes.

CREAM OF MUSHROOM SOUP (9 quarts, 48 three-fourth cup servings)

3 lb. mushrooms	1 gal. hot water or chicken or veal broth
¾ c. minced onion	1 gal. evaporated milk
1¼ c. butter	2½ tbsp. salt
2 c. flour	Pepper

Wash mushrooms. Separate stems and caps. Slice caps. There should be 1 gallon. Put stems through grinder. There should be 2½ cups packed. Cook onion and mushrooms slowly in the butter, about 15 minutes. Sift flour over mushrooms and blend thoroughly. Add hot water gradually, stirring constantly. When soup has thickened slightly, add milk, salt and pepper. Stir while heating, or heat over boiling water.

CREAM OF TOMATO SOUP (10 quarts, 53 three-fourth cup servings)

3 qt. evaporated milk	2 tsp. salt
1 qt. hot water	½ tsp. pepper
2 No. 10 cans concentrated tomato soup (1½ gal.)	

Mix milk and water in top of double boiler. Pour in the tomato soup, stirring to combine well. Add salt and pepper and heat over boiling water.

MINTED CREAM OF PEA SOUP (4½ quarts, 24 three-fourth cup servings)

2¼ qt. cooked or canned peas	2 tbsp. butter or chicken fat
1 onion, sliced	2 tbsp. flour
3 tbsp. sugar	2 tsp. salt
1½ tbsp. salt	1 qt. broth or water
12 sprigs mint	1 qt. evaporated milk

Simmer peas 5 minutes with onion, sugar, salt, and mint in the liquid in which the peas were canned or cooked. Rub through a coarse sieve. There should be about 2 quarts pulp and liquid. If not, add water. Melt fat. Stir in flour and salt and blend well. Add broth. Cook until sauce begins to thicken, stirring constantly. Combine with vegetable pulp and liquid. When ready to serve, add milk and heat thoroughly.

CURRY OF SPINACH SOUP (12 quarts, 65 three-fourth cup servings)

¾ c. butter	Liquid drained from spinach plus water to make 3 qt.
¾ c. flour	8 qt. evaporated milk
½ c. curry powder	6 No. 2 cans chopped spinach (7½ c.)
1½ tbsp. salt	

Melt butter. Blend in flour, curry powder and salt, keeping smooth. Stir in liquid from spinach plus water. Stirring constantly, cook until mixture begins to thicken. Add milk and spinach and heat to serving temperature.

CHILI BEAN CHOWDER

(12½ quarts, 67 three-fourth cup servings)

4½ qt. cooked dried kidney beans (8 No. 2½ cans)	¼ c. chili powder
4 qt. cold water	¼ c. oregano powder
¼ c. salt	8 tall cans evaporated milk (approx- imately 3¼ qt.)
8 medium onions, chopped	
1 bulb garlic	

Add water, salt, onion, garlic, chili powder and oregano to kidney beans and simmer slowly until onion is tender and spices are fully blended. Remove garlic. Heat milk to proper serving temperature and add to kidney bean mixture. (Do not boil milk as the mixture may curdle.) Serve at once.

Note: 4 quarts cooked dried pinto beans may be used.

ONION AU GRATIN SOUP*

(1¼ quarts, 6 three-fourth cup servings)

2 bunches green onions or 3 dry onions, chopped	2¼ c. evaporated milk
3 tbsp. butter	Few grains cayenne
3 c. beef broth or	Salt and pepper
3 c. hot water with	3 stale rolls, cut in halves
3 bouillon cubes dissolved in it	1 cup grated cheddar cheese

Saute onions in butter for a few minutes, being careful not to brown them. Add broth and simmer until onions are tender, then add milk and seasonings. Pour into individual casseroles over rolls. Sprinkle rolls with cheese and toast under broiler. Or: Toast cheese on rolls and then place in bowls of soup.

*Note: This and a few of the recipes which follow are written in amounts suited to the selective menu where their inclusion would be most appropriate.

CREAM OF CUCUMBER SOUP

(3½ cups, 5 two-third cup servings)

2 c. diced, peeled cucumber	2 bouillon cubes
¼ c. chopped onion	Pepper
1½ c. boiling water	1 c. evaporated milk
½ tsp. salt	

Boil cucumber and onion in water with salt, pepper and bouillon cubes until cucumber is tender, about 10 minutes. Sieve. Add milk and reheat to serving temperature.

Note: For cold soup, chill cucumber puree, add cold milk and serve.

VEGETABLE CHOWDER

(12½ quarts, 67 three-fourth cup servings)

1 c. butter	3 qt. canned tomatoes
1½ pt. chopped onion	¾ qt. canned green beans
¾ qt. canned corn (cream style)	2 tbsp. salt
	2½ qt. evaporated milk, heated

Melt butter in soup kettle. Add onions, cover and cook slowly 5 to 10 minutes. Do not brown. Add vegetables and salt and continue cooking until tomatoes break apart. Stir occasionally to prevent scorching. When ready to serve, stir in the milk. Milk should not be added before chowder is ready to be served since reheating may curdle the mixture.

CORN CHOWDER

(12½ quarts, 67 three-fourth cup servings)

¾ lb. salt pork	2 tbsp. salt
5 onions, sliced	½ c. sugar
3 qt. canned corn	Pepper
2½ qt. diced potatoes	5¼ qt. boiling water
2 qt. raw or canned tomatoes	1¼ qt. hot evaporated milk (3 tall cans)

CORN CHOWDER—(Continued)

Cut pork into small pieces and fry slowly to a golden brown in a large soup kettle. Add onion and cook slowly without browning, about 5 minutes. Add corn, potatoes and tomatoes in alternate layers. Sprinkle with salt, sugar and pepper, then add water and cook slowly until potatoes are tender. Add milk when ready to serve. Chowder is generally served by pouring over pilot biscuit or cracker in soup bowl.

CREME VICHYSOISE

(2¼ quarts, 12 three-fourth cup servings)

2 c. chopped onions	2 tsp. salt
2½ c. diced potatoes	¼ tsp. pepper
2 c. chicken broth	2 tbsp. minced chives
1 tbsp. chicken fat	or ¼ tsp. paprika
2 c. evaporated milk	

Cook onions with potatoes in about 4 cups boiling water until tender, about 40 minutes. Press through a fine sieve. Add the broth, fat, milk, salt and pepper, and mix thoroughly. Reheat to blend. Serve hot or very cold, garnished with minced chives or paprika.

Note: Do not add fat or butter if soup is to be served cold.

BEEF BORSCH

(4 quarts, 25 two-third cup servings)

2 qt. peeled, coarsely grated beets	3 tbsp. sugar
2 c. finely chopped onion	3 egg yolks
2½ qt. water	3 tall cans evaporated milk (5 c.)
5 tsp. salt	¼ c. vinegar or lemon juice

Cook beets and onion in water with salt and sugar until vegetables are soft. Add mixture of well beaten egg yolks and milk slowly, stirring constantly. Stir in vinegar or lemon juice just before serving. May be served hot or cold.

Note: Cabbage and tomato (combined) or sorrel (Stchav), beet greens or spinach may be made into a borsch, using evaporated milk in the same way.

OYSTER STEW

(13½ quarts, 72 three-fourth cup servings)

12 tall cans evaporated milk (5 qt.)	2½ c. cracker crumbs
5½ qt. boiling water	1 gal. oysters
1 onion, sliced	½ c. butter
Celery tops and outside stalks from large bunch	2 tbsp. salt
Parsley	1 tsp. paprika

Scald milk and water with onions, celery and parsley over boiling water about 15 minutes. Remove celery, onion and parsley and add cracker crumbs. Remove any bits of shells from oysters and heat in their own liquid until edges curl. When ready to serve, add oysters and liquid to milk with butter, salt, and paprika. Do not overcook the oysters.

CLAM CHOWDER

(2 quarts, 11 three-fourth cup servings)

2 c. cooked clams	Liquid drained from clams plus enough water to make 2 c.
2 tsp. butter	
1 medium onion, finely chopped	½ tsp. salt
2 c. diced potato	Few grains pepper
	2 c. evaporated milk

Drain clams, reserve liquid. Melt butter and add onion. Cook until soft but not brown. Add potatoes, liquid and seasonings. Cover and simmer until potatoes are cooked. Add the cooked clams and heat to boiling temperature. Heat milk over boiling water, then add to chowder just before serving.

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LEEK AND POTATO SOUP (4 quarts, 21 three-fourth cup servings)

2 qt. diced potatoes
2 1/2 c. thinly sliced leeks (1 bunch)
2 qt. boiling water
3 tsp. salt
2 tall cans evaporated milk (3 1/2 c.)
3 c. tiny bread cubes fried in butter

Boil potatoes and leeks in water until tender, about 30 minutes. Strain if desired. Add salt and milk and heat before serving. Garnish with bread cubes.

SCHOBEL (32 squares approximately 1 1/2 by 1 1/2 inches)

2 tbsp. butter
2 tbsp. flour
1/4 tsp. salt
2 eggs
2 tbsp. evaporated milk

SCHOBEL—(Continued)

Cream butter, flour and salt together. Beat egg yolks. Add milk and mix. Combine with first mixture. Beat egg whites and fold into milk mixture. Pour into well greased shallow pan 12 1/2 x 8 inches. Bake in moderate oven (375 deg. F.) until brown, about 15 minutes.

CHEESE STRAWS (130 to 140 three-inch straws)

1 c. sifted all-purpose flour
1 1/2 tsp. baking powder
1/2 tsp. salt
2 tbsp. shortening
1/2 c. grated cheese
5 tbsp. evaporated milk
Paprika

Sift dry ingredients together. Cut in shortening and cheese, using two knives or a pastry blender, until like coarse corn meal. Add milk and mix well. Roll dough to about 1/8 inch thickness in rectangular shape. Place on greased cookie sheet and cut into strips 3 inches long and 1/4 inch wide. Sprinkle with paprika. Bake in hot oven (425 deg. F.) for 8 to 10 minutes, or until brown.

FOOD FOR THOUGHT

MEAL PLANNING AND TABLE SERVICE. By Beth Bailey McLean, director, Martha Logan Service, Swift and Company, and formerly associate professor, Division of Home Economics, Iowa State College, Peoria, Ill.: *The Manual Arts Press*, 1949. Completely revised and reset. Illustrated. Pp. 167. Price \$3.50.

It is said that 90,000 copies of this book have been sold in the school edition, a fact which doubtless influenced the preparation of this present edition. While designed primarily for the family group, the content is generally applicable to the larger institutional group. Such chapters as these—principles of menu making, menus and service for special occasions, and how to serve food attractively—have a universal application. Even the chapters on "gracious dining," the choice of equipment, and rules for table service may serve to settle many moot points of service and etiquette, ranging from proper methods of carving the roast to that of correct manipulation of the knife and fork in the hands of the guest, with excellent illustrations.

Since many hospital dietitians are expected to be caterers for special occasions as well, the instructions for various types of buffet service (with appropriate menus), luncheons, teas, receptions and afternoon and evening collations will refresh the imagination and serve as an authoritative reference on accepted procedures.

For those who have the time, patience and inclination toward the

more elaborate garnishes—those who would convert the cucumber into a calla lily and the turnip into a tulip—this book is their oyster. But there are plenty of other more mundane methods for the less nimble-fingered. In fact, we have yet to see a book that covers this subject more thoroughly.

—MARY P. HUDDLESON.

Improved Salt

Many people think of iodine as a brown liquid in the medicine chest rather than as a food essential. Yet small but steady quantities of iodine are needed by the body for normal growth and development, healthy skin and hair, alert mentality and physical vigor, as well as for preventing goiter. The simplest, most practical and least expensive way to make sure that all people, especially growing children, have the iodine they need is the use of iodized salt. Vegetables and fruits grown on iodine-rich soil, seafoods and some drinking water contain iodine. But many people lack these sources. Large areas of this country are deficient in iodine.

This is why the U.S. Department of Agriculture is cooperating with the U.S. Public Health Service—and physicians, nutritionists and other groups concerned with national health—in the campaign for general use of iodized salt. Homemakers are urged to look for the word "iodized" when buying salt at grocery stores to make sure they are getting this health protection for their families. Because only one part

iodine in 10,000 parts salt is needed, iodized salt is no more expensive than is salt without this nutrient. The major salt producers are willing to comply with the demand for it.

Iodine is essential for a healthy thyroid gland which in turn affects the growth and general well-being of the body. Iodine hunger is the cause of much fatigue among adolescents, physicians say. Physicians have found that giving iodine to mothers has reduced the number of miscarriages and aided mothers in having enough milk for their infants. The use of iodized salt in areas where goiter was prevalent has proved a most effective means of preventing this disease.

Iodine is naturally present in salt from the ocean and in many local salt deposits in the earth but is lost in refining. Returning iodine to salt is similar to enriching flour to make up for vitamins and minerals removed from the grain in milling.

Potato Shift

As the potato crop has become more specialized and concentrated, it has been shifting to large acreages in California, Idaho and Maine while dropping off in the Lake States. The most rapid increase in recent years has been in Kern County, California, where large yields of potatoes are obtained under irrigation.

Potato production in this country has been rising since 1919, except for several years in the early 1930's. New high records were made in the early 1940's. The increase has come not only from large scale, specialized growing but also from higher yielding varieties, more fertilizer, and more effective control of insects and diseases.



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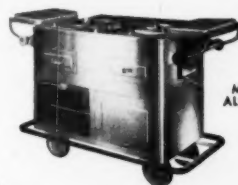
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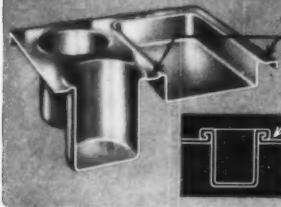


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Visit us also at our exhibit at the National Restaurant Show, Navy Pier, Booths No. 723-726, Chicago, Ill., May 23-26

Menus for May 1950

Mary Louise Manning
Bon Secours Hospital
Baltimore

- | | | | | | |
|---|---|--|--|--|--|
| 1
Stewed Prunes
Poached Egg
•
Tomato Consommé
Rib Roast Beef au jus
Parslaid Potatoes
Buttered Spinach
Strawberry Chiffon Pudding
•
Lamb Stew and Vegetables
Hot Biscuits
Sliced Tomato and Pepper
Salad
With French Dressing
Chocolate Blancmange | 2
Grapefruit Juice
Broiled Bacon—Toast
•
Vegetable Soup
Broiled Calf's Liver With
Thin Gravy
Creamed Potatoes
Glazed Carrots
Maple Ice Cream
•
Stuffed Green Peppers
With Meat, Rice and
Tomato Sauce
Fresh Fruit Salad on
Lettuce
Clover Leaf Rolls
Cherry Whipped Gelatin | 3
Sliced Bananas and Cream
Soft Cooked Egg
•
Scotch Broth
Broiled Tenderloin Steak
With Sautéed Mushrooms
Mashed Potatoes
Buttered Fresh Peas
Lemon Meringue Tarts
•
Cold Sliced Ham, Pickles
Coleslaw on Lettuce
Buttered Noodles
Hot Biscuits
Fresh Strawberries, Cream | 4
Fresh Orange Juice
French Toast, Maple Sirup
•
Chicken Noodle Soup
Meat Loaf With Tomato
Gravy
Baked Potato
Mashed Summer Squash
Vanilla Ice Cream
•
Chicken à la King on
Toast Points
Tossed Salad and Oil
Dressing
Candied Sweet Potatoes
Fresh Pineapple | 5
Fresh Applesauce
Poached Egg, Toast
•
Cream of Pea Soup
Broiled Halibut With
Lemon Butter
Mashed Potatoes
Buttered Broccoli
Sponge Cake
•
Cheese fondue
Molded Fruit Salad,
Lettuce
With Cream Dressing
Hard Rolls, Currant Jelly
Raspberry Ice
Almond Cookies | 6
Tomato Juice
Omelet, Toast
•
Chicken Gumbo Soup
Broiled Lamb Chops,
Mint Jelly
Escalloped Potatoes
Buttered Baby Lima Beans
Devil's Food Cake
•
Celery Hearts
Tomatoes Stuffed With
Ham Salad on Lettuce
Buttered Spaghetti
Apricot Marlow |
| 7
Fresh Peaches, Cream
Grilled Bacon
•
Jellied Consommé
Broiled Chicken With
Pan Gravy
Baked Idaho Potato
Buttered New Green Beans
Lettuce Salad, Thousand
Island Dressing
Chocolate Ice Cream
•
Sliced Corned Beef—Relish
Potato Salad, Lettuce
Radishes, Carrot Sticks
Fruit Gelatin With
Whipped Cream | 8
Stewed Raisins
Scrambled Eggs
•
Cream of Mushroom Soup
Roast Leg of Lamb With
Mint Sauce
Potatoes au Gratin
Buttered Cauliflower
Nesselrode Pie
•
Italian Spaghetti
With Meat Balls
Spring Salad,
French Dressing
Peach Melba | 9
Pineapple Juice
Petite Pancakes, Sirup
•
Vegetable Soup
Veal Birds
Buttered New Potatoes
Escalloped Squash
Fresh Strawberries, Cream
•
Club Sandwiches With
Sweet Pickle and
Celery Curis
Baked Stuffed Potato
Butterscotch Sundae | 10
Soft Cooked Egg
Blueberry Muffins
•
Beef Bouillon
Chicken Fricassee
Steamed Rice
Whole Buttered New Beets
Apple Pie and Cube Cheese
•
Baked Stuffed Tomato
With Bacon Strips
Perfection Salad on
Lettuce
Sliced Banana
Toll House Cookies | 11
Blended Juice
French Toast, Maple Sirup
•
Chicken Noodle Soup
Baked Ham in Gingerale
Mashed Sweet Potatoes
Creamed Celery
Citrus Fruit Cake
•
Large Fruit Salad With
Cottage Cheese on Lettuce
Corn Muffins, Honey
Raspberry Sherbet | 12
Fresh Strawberries, Cream
Poached Egg
•
Cream of Spinach Soup
Baked Salmon With
Parsley Butter
Mashed Potatoes
Wax Beans Plaquant
Graham Cracker Pudding
•
Tuna à la King on Toast
Baked Acorn Squash
Lettuce Wedge With
1000 Island Dressing
Peach Shortcake |
| 13
Apricot Nectar
Scrambled Eggs
•
Beef Broth
Swiss Steak With Gravy
Lyonnaise Potatoes
Minted Carrots
Frosted Spice Cake
•
Creamed Chipped Beef
Hot Biscuits
Buttered Asparagus
Celery Hearts and
Radish Roses
Applesauce | 14
Orange Juice
Canadian Bacon
•
Jellied Consommé
Roast Chicken, Dressing
Mashed Potatoes
Buttered New Peas
Fresh Peach Ice Cream
•
Ham and Veal Salad Mold
on Lettuce
Potato Chips
Corn Sticks
Olives, Celery Hearts
Fresh Strawberries, Cream | 15
Baked Eggs, Cinnamon
Toast
Kadota Figs
•
Vegetable Soup
Pot Roast Beef In Gravy
Parslaid Potatoes
Buttered Spinach
Apple Betty With
Hard Sauce
•
Grilled Cheese Sandwiches
With Broiled Tomato
Slices
Shredded Lettuce With
French Dressing
Chocolate Blancmange | 16
Grapefruit Juice
Grilled Bacon
•
Philadelphia Pepper Pot
Tenderloin Steak With
Mushrooms
Creamed Potatoes
Buttered Broccoli
Cantaloupe
•
Chicken Loaf, Cream Sauce
Harvard Beets
Celery and Carrot Curis
Prune Whip | 17
Stewed Apricots
Soft Cooked Egg
•
Mulligatawny Soup
Roast Leg of Lamb,
Mint Jelly
Escalloped Potatoes
Buttered Fresh Green
Beans
Frosted Fruit Cup Cakes
•
Sliced Tomato, Bacon and
Lettuce Sandwiches
Fruit Salad With Cream
Dressing
Tapioca Custard Dessert | 18
Apple Juice
Scrambled Egg
•
Chicken Barley Soup
Roast Veal, Dressing
Sweet Potato Soufflé
Buttered Cauliflower
Lemon Ice
•
Assorted Cold Cuts on
Lettuce, Chili Sauce
Potato Chops
Asparagus Tip Salad,
French Dressing
Brownies With Whipped
Cream |
| 19
Spiced Fruit Juice
Petite Pancakes
•
Cream of Asparagus Soup
Baked Trout With
Spanish Sauce
Baked Idaho Potato
Buttered Baby Lima Beans
Melon With Lemon Slice
•
Salmon Loaf With
Cream Sauce
Buttered New Peas
Tossed Salad With French
Dressing
Baked Apple in Grenadine | 20
Prune Plums
Poached Egg, Coffee Cake
•
Oxtail Soup
Broiled Lamb Chop With
Pineapple Slice
O'Brien Potatoes
Stewed Tomatoes
Chocolate Chiffon Pie
•
Salisbury Steak, Gravy
Potato Sticks Hot
Molded Vegetable Salad
Brandy Flavored Cornstarch
Pudding | 21
Fresh Peaches, Cream
Broiled Ham Slice
•
Chicken Rice Soup
Baked Ham, Dressing
Mashed Potatoes
Buttered Spinach With
Hard Cooked Egg Garnish
Vanilla Ice Cream
•
Chicken and Celery Salad
With Macaroni Salad
on Lettuce
Shredded Carrots
Fruit Compote
Icebox Cookies | 22
Half Grapefruit
Scrambled Eggs
•
Scotch Broth
Rib Roast Beef au jus
Parslaid New Potatoes
Corn and Peppers
Old-Fashioned Peach Cake
•
Lamb Stew With
Vegetables
Puff Pastry
Cucumber and Sour Cream
Orange Bavarian Crème | 23
Prune Juice
Canadian Bacon
•
Vegetable Soup
Individual Veal Cutlets
With Tomato Puree Sauce
Potatoes au Gratin
Buttered Fresh Asparagus
Strawberry Shortcake
With Whipped Cream
•
Creamed Chipped Beef and
Mushrooms, Sweet Pickles
Beaten Biscuits
Buttered Peas
Fresh Applesauce | 24
Sliced Banana, Cream
French Toast, Jelly
•
Jellied Tomato Consommé
Roast Turkey, Dressing
Mashed Potatoes
Frozen Buttered Kale
Raspberry Ice
•
Sliced Corned Beef With
Pickled Watermelon Rind
on Lettuce
Noodles au Gratin
Chocolate Layer Cake |
| 25
Spiced Fresh Peas
Scrambled Eggs
•
Split Pea Soup
Roast Spring Lamb With
Mint Sauce
Baked Potato
Buttered Squash
Peach Betty With
Hard Sauce
•
Turkey and Noodle
Casserole
Waldorf Salad on Lettuce
Parkerhouse Rolls, Jelly
Fresh Strawberries, Cream | 26
Orange Juice
Petite Pancakes, Sirup
•
Clam Chowder
Broiled Fish Steak With
Lemon Butter
Potato Balls With Parsley
Harvard Beets
Fresh Crushed Pineapple
Graham Crackers
•
Egg Cutlets With Peas
Pear and Ginger Salad on
Lettuce
Buttered Hominy
Cream Puffs | 27
Stewed Prunes
Shirred Eggs
•
Beef Barley Soup
Smothered Steak in Broth
Mashed Potatoes
Braised Celery
Harlequin Block
•
Meat Loaf With Brown
Gravy
Candied Fresh Carrots
Lettuce Wedge With
Mauvonneise
Peach Upside-Down Cake | 28
Whole Orange Sections
Canadian Bacon
•
Clear Chicken Broth
Fried Chicken With
Milk Gravy
Baked Sweet Potato
Buttered Wax Beans
Orange Chiffon Cake
•
Sliced Baked Ham With
Mixed Pickle
Escalloped Tomatoes
Fresh Peaches and Cream
Sugar Cookies | 29
Pineapple Juice
Corn Muffins
•
Mulligatawny Soup
Veal Chops With Gravy
O'Brien Potatoes
Baked Acorn Squash
Apple Tarts With Cheese
•
Shrimp à la Newburg
Cloverleaf Rolls
Marinated Vegetable Salad
on Lettuce
Strawberry Marlow | 30
Stewed Raisins
Poached Egg, Toast
•
Chicken Rice Soup
Sliced Tongue With
Raisin Sauce
Mashed Potatoes
Buttered Green Beans
Fresh Fruit Compote,
Molasses Cookies
•
Tomato Juice
Welsh Rabbit With
Bacon Strips
Buttered Peas and Celery
Caramel Fudge Sundae |
| 31
Grapefruit Sections, Broiled Bacon • Alphabet Soup, Lamb Croquettes With Gravy, Parslaid New Potatoes, Pickled Whole Small Beets, Rhubarb Pie • Molded Fruit Salad on Lettuce, Cream Cheese and Jelly Toasted Sandwiches, Gingerbread With Chocolate Sauce. | | | | | |

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Maintenance and Operation

STOP BURNING UP THE HOSPITAL'S MONEY

ENGINEERING usually connotes an accurate determination of facts, carefully analyzed premises, scientifically arrived at conclusions, and slide rule precision in execution. That's what hospitals need.

There is an interesting paper in the January 1948, issue of the *Journal of the A.S.H.V.E.* in which are suggested some fundamentals, which seem elementary even to a layman, to the effect that the first step in designing any heating system is the calculation of losses in the building, transmission coefficients, infiltration and the difference between the outside and inside design temperatures. It states that the first and operating costs and general satisfaction over years to come will be determined by these calculations.

In the 29 volumes of the journal of the society, from 1916 to 1944, only two papers deal with winter design temperature. One in 1924 recommends that it should not be more than 15 degrees above the lowest temperature recorded in the last 10 years; the other in 1944 recommends that a temperature somewhat higher than the lowest daily mean on record should be used. The daily mean temperature is a better indication of the heating load than is the daily minimum, as the latter usually prevails for such a short time that its effect on the heating load is negligible. An oversized system is difficult to control and causes more discomfort than a smaller system will on a few extremely cold days. The author states, significantly:

"The outside design temperature is too important a factor to be determined on the basis of one cold day. A logical method of design temperature selection is urgently needed; without it . . . heating design in hundreds of communities will continue to be based on some unreliable rule of thumb." The author of these ABC's

This is the second section of Mr. Neergaard's article on hospital heating systems. The first section appeared in the March issue of this magazine.

CHARLES F. NEERGAARD
Agnew, Neergaard and Craig
Hospital Consultants
New York City

of heating practice was Clark M. Humphries, the senior engineer of the A.S.H.V.E. laboratories. One would get the impression that many of our hospital heating plants have been designed by a rule of thumb with boilers and radiators big enough to heat the building on that one low temperature day recorded in the last 10 years.

PANEL HEATING is ideal for the hospital. In the cold winter of 1929 I worked for six weeks in London in a panel heated office and was perfectly comfortable in a 60° F. temperature. I studied the principles of the system, how it was engineered and operated. I found that in the many public schools maintained by the London County Council those which had radiant panel heat used from 30 to 40 per cent less fuel than did those having radiators. I have a recent letter from Troughton & Young, English heating engineers, giving their experience with two identical buildings of the Postal Sorting Office in London, one heated by hot water radiators, the other by panel warming. Tests covering 12 weeks by His Majesty's Office of Works showed 43 per cent greater fuel consumption in the radiator heated building.

I have long advocated panel heat for our hospitals here but have met with only doubts and objections. These, save for the question of first cost, are convincingly answered in a 1937 report⁵ of the Central Bureau of Hospital Information, London. It was based on the experience of 42 English hospitals covering 15 to 20 years, with an aggregate of 232 heating seasons:

There were no leaks and no repairs required to any of the embedded panels.

Cracks and discoloration of ceilings were negligible.

Less cleaning and less frequent redecoration were needed.

Control valves in each room were rarely used, the central control of the circulated water temperature in the boiler room being sufficient.

Warmth was evenly distributed and comfortable temperatures were maintained.

One medical director who has both kinds of heat in his hospital buildings states: "Panel heating is cheaper to run, is equally efficient compared with radiator heating, is cleaner, reduces repainting costs as dust is not carried by convection to the ceiling, and is safer and less liable to cause accident burns. It is dustproof and should and does prevent infection of the dustborne variety. The absence of air currents in the panel warmed villas has shown a marked decrease in the infectious disease incidence as compared to those with radiators."

An article in "*Schweizerische Bauzeitung*," April 19, 1947, reports on the operating experience of 170 installations of panel heating in Switzerland from 1937 to 1947. There were 34 in hospitals, 85 in office buildings, schools and so forth and 51 in residences. The total tube length was nearly 450 miles and no leaks have occurred in any building.

Many American engineers question the English claims of economy for panel heating. A booklet of the Revere Copper and Brass Company states, "English claims of 50 per cent savings are more notable for optimism than accuracy, a claim of 15 per cent saving cannot with present data be either proved or repudiated." On the other hand, the chief engineer of the Byers Company sent me six examples of comparable buildings which show fuel savings of from 30 to 60 per cent.

I for one am convinced that, given insulated buildings and proper structural and heating design, panel heating, if anything, should cost less to install than radiators. Prefabricated coils in flat slab construction might eliminate hung ceilings and plaster, save weight and cubage; cushioned floors would

WITH A SCOOP OF THE ARM, operator easily slides load from Troy "Slide-Out" Washer into extractor basket. Washer cylinder automatically stops with load on waist-high partition. Photo courtesy ENGLEWOOD HOSPITAL, CHICAGO.



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control sound transmission. Several hospital projects now on the drawing boards will soon give the answer.

This paper deals essentially with the waste in extravagant engineering and uninsulated buildings which influence the cost of heat and steam. Chapters in similar vein could be written on ventilation, air conditioning and electrical service.

Hospital bookkeeping groups power, light and heat in one account, the bulk of the cost with 40 per cent for fuel being in the last. Tables 3 and 4 present a challenging comparison. In the light of the experience of the five hospitals which spend from \$74 to \$188 a bed a year, with but one-fourth to one-half of their acreage of walls insulated, it would be conservative to anticipate that, if hospital plants were properly designed, an average cost of \$75 a bed a year would be conservatively practicable.

In 1947, thirty-six hospitals in the New York area with 6906 beds spent an aggregate of \$1,770,000 for power, light and heat (of which the fuel cost alone was \$690,000). This represents an average of \$256 a bed. If we were to build these hospitals today, fully insulate all buildings and design economical boiler plants, the saving at \$75 a bed would exceed a million and a quarter dollars. Furthermore if we used panel heating throughout, with only a 25 per cent reduction in fuel costs, there would be an additional saving of \$172,500. This for only 36 hospitals—and we have hundreds to build. Let's not burn up hospital money in the future!

For years architects, engineers and building committees have felt the need for simple authoritative yardsticks whereby they could determine what the hospital should have in its various mechanical services for power, heat, ventilation, air conditioning and electrical equipment. At last they are available—thanks to the vision, initiative and research of the Division of Hospital Facilities of the U.S. Public Health Service—Vane Hoge, Marshall Shaffer and their consulting engineer, C. E. Daniel. The "Mechanical Section" of the "Functional Basis of Hospital Planning," recently issued, is potentially the most valuable contribution to the economies of hospital planning that I have seen in 30 years of hospital work. Based on the successful experience of an engineer who has designed many hospital plants which have proved sound and economical, it

Table 1—Comparison of Radiation in Various Buildings
With and Without Insulation

THE NUMBER OF CUBIC FEET IN THE BUILDING TO EACH SQUARE FOOT OF RADIATION					
HOSPITALS COMPLETED	C.F. of Building	S.F. of Radiation	No. of C.F. to Sq. S.F. of Radiation	Insulation	
				Walls	Windows
Prince Edward Island, Canada...	550,000	5,100	107	Yes	Yes
Bethlehem, Pa.....	750,000	3,750	200	Yes	Yes
Hagerstown, Md.....	560,000	3,590	156	Yes	Yes
New Haven, Conn.....	1,605,000	13,248	121	Yes	Yes
Toronto, Ont.....	1,880,000	16,600	113	Yes	Yes
HOSPITALS BEING PLANNED					
Scranton, Pa.....	333,000	3,343	99	Yes	No
Long Island.....	514,000	7,320	70	Yes	No
New Jersey.....	425,000	6,600	65	No	No
Glens Falls, N. Y.....	605,000	7,400	85	Yes	No
Virginia.....	1,137,521	23,813	47	Yes	No

Heating contractors roughly estimate heating plant installations @ \$6.50 per sq. ft. of radiation, including boilers and equipment.
In the first group all except Prince Edward Island are wings added to existing structures.

Table 2—Summary of Steam Requirements for a 100 Bed Hospital

Use	Maximum Horse Power	Steam Pressure	Hours Per Day at Varying Loads
General heating system.....	68	2	24
Special heating, operating and delivery rooms.....	2	2	6
Domestic hot water supply.....	10	2	16
Laundry:			
Hot water.....	15	2	7
Steam.....	11	100	7
Kitchen and dish-washing.....	6	2-20	6
Sterilizing.....	10	40	5
	122		

explains, defines and clarifies all elements of the mechanical plant—heat, steam, electrical—the most obscure and least understood third of the hospital's capital investment. It is presented in terms which the average layman can understand. Inconspicuously buried in the text are certain yardsticks which may serve as a guide in the planning of every new hospital:

"Boiler capacity may be roughly estimated at 1 h.p. per bed when the heat is figured at zero temperature."

"Two-thirds of the boiler capacity is required for heating and one-third for hot water, laundry, sterilizers and so forth."

"Heat requirements may be roughly

Table 3—Hospital With All or a Portion of the Buildings Insulated

No.	Location	No. Beds	Days Care	Total Cost	Power, Light and Heat Cost		
					Per Bed Per Yr.	Patient Per Diam	Proportion Insulated
Toronto, Ont.....	547	175,488	\$ 40,622	\$ 74	\$0.23	1/2	
Prince Edward Island, Canada.....	200	54,037	19,373	97	.36	All	
Hagerstown, Md.....	170	57,783	27,718	163	.48	1/2	
Glens Falls, N. Y.....	162	59,208	19,048	117	.32	1/2	
Bethlehem, Pa.....	307	89,001	58,153	188	.65	1/4	

Table 4—Hospitals Which Are Uninsulated

2 New York City.....	520	152,686	\$163,129	\$314	\$1.07
3 Brooklyn.....	341	96,966	117,897	346	1.22
8 New Jersey.....	284	71,856	71,367	251	.99
10 Long Island.....	236	69,040	77,023	326	1.12
13 Central New York State.....	218	66,323	43,509	200	.66
14 New Jersey.....	207	56,588	65,317	316	1.16
19 Northern New York State.....	150	41,959	27,828	186	.66
20 New York City.....	131	29,741	58,541	447	1.97
22 Connecticut.....	134	36,157	43,130	322	1.19
25 Long Island.....	110	32,843	36,775	334	1.12
29 Westchester County, N. Y.....	100	28,261	33,975	340	1.20
35 Brooklyn.....	143	30,288	43,875	307	1.45

The local figures are from a group of hospitals with uniform accounting.

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Table 5—Hospital Boiler Plants Which Are Supplying Ample Heat and Steam With One Boiler Horse Power or Less per Bed

Location	Erected*	Buildings	No. Beds	No. Boilers	Boiler Horse Power		Approx. Space Insulated
					Winter	Standby	
Brooklyn, N. Y.	1918	3	100	2	100	100	0
Hagerstown, Md.	1936	5	158	2	130	130	1/3
Bethlehem, Pa.	1945	11	295	3	300	150	1/4
Stamford, Conn.	1940	2	70	2	60	60	0
Bangor, Me.	1940	8	213	3	136	2 @ 60	1/4
Rome, N. Y.	1939	1	135	3	109	2 @ 63	0
New Haven, Conn.	1941	8	385	3	300	150	1/2
Westchester County, N. Y.	1945	4	145	3	150	2 @ 100	0
Glens Falls, N. Y.	1936	2	162	3	150	150—60	1/2
Prince Edward Island, Canada	1937	2	200	2	60	60	All
Toronto, Ont.	1932	4	547	2	250	250	1/2
White Plains, N. Y.	1939	4	196	3	160	2 @ 106	1/2
Yonkers, N. Y.	1929	6	195	2	125	125	None
Total Beds.....			2,801	Total Boiler H.P.		3,923	
				Average H.P. per Bed.....		1.4	

*—Date erected is for most recent building when usually a new, large boiler was installed to carry the winter load. Only at Bangor and Rome were boilers designed economically to supply the reduced steam demand in the summer months. Rome has a 109 h.p. low pressure and two 63 h.p. high pressure.

Table 6—Comparison of the Number of Boilers and Horse Power Capacity Provided in Various Hospitals Built and Projected and the Ratio of Maximum Horse Power per Bed

TEACHING HOSPITALS IN THE NEW YORK AREA:	No. Buildings	No. Beds	No. Boilers	Total Boiler Horse Power	Horse Power Per Bed
Hospital No. 1.....	9	406	2 @ 200 1 @ 300	700	1.7
Hospital No. 2.....	10	1,012	5 @ 500	2,500	2.5
Hospital No. 3.....	9	1,350	4 @ 800	3,200	2.4
Hospital No. 4.....	3	357	2 @ 300	600	1.7
Total.....		3,125		7,000	2.2
GENERAL HOSPITALS IN NEW YORK METROPOLITAN AREA:					
Hospital No. 5.....	7	340	6 @ 160	960	2.8
Hospital No. 6.....	6	410	3 @ 300	900	2.2
Hospital No. 7.....	9	520	1 @ 500 2 @ 200 2 @ 286	1,472	2.8
Hospital No. 8.....	7	650	2 @ 800 1 @ 400 1 @ 531	1,600	2.5
Hospital No. 9.....	10	800	1 @ 346 1 @ 373 1 @ 504	2,154	2.8
Hospital No. 10.....	5	192	2 @ 250	500	2.6
Total.....		2,912		7,586	2.6
HOSPITALS PROJECTED:					
Monroe County, Pa.....	4	137	2 @ 108 2 @ 60	336	2.5
Virginia.....	1	150	2 @ 225	450	3.
Long Island.....	1	50	2 @ 125	250	5.
Glens Falls, N. Y.....	3	232	3 @ 120	360	1.6
Total.....		569		1,396	2.5
12 HOSPITALS IN TABLE V...		2,801		3,923	1.4

Note: No provision is made for economical summer operation, for which approximately 1/3 boiler horse power per bed is needed.

estimated as 1 square foot of radiation to 80 cubic feet of space for uninsulated buildings.

"When the walls are well insulated the size of the heating boilers and radiators can be reduced approximately 25 per cent; if, in addition, the windows are effectively double glazed, 50 per cent, or approximately 1 square foot of radiation to 160 cubic feet of space."

These guides, together with similar data on ventilation, plumbing, air conditioning and electrical service, will now make it possible for the architect, engineer and building committee to arrive at a sound basis for determining what the mechanical plant ought to be.

The validity of the ratio of 1 boiler h.p. per bed to carry the winter load is evidenced by the hospitals in Table 5. Six of these hospitals have no insulation, yet 1 h.p. has proved more than enough. Toronto with half of its buildings insulated requires but 1/2 h.p. In but few of the plants is proper provision shown for the low steam demand in the summer months. This is usually due to the fact that when new buildings were added, the existing boilers were continued and one new one was installed to carry the combined winter load.

Table 6 is a significant comparison of the maximum h.p. per bed in existing and projected hospitals. In these comparisons of boiler plants and operating costs there are obviously many variables, as I have already outlined. However, the material as presented is at least suggestive that insulated buildings and conservatively engineered mechanical services can save millions of dollars annually in our expanding hospital program as compared to what we have wasted in the past.

The building committee, architect, engineer and consultant, given the yardsticks now available, can apply a controlling pattern to a hitherto largely uncontrolled major factor in hospital planning, with the result that the paramount concern of the hospital trustee, his operating budget, will benefit in large measure, and we shall burn up less hospital money.

Recommendations and Conclusions:

Having challenged engineering standards and practices, it is proper to suggest what to do about them in the future:

The building committee should exercise as much care in the selection of its engineer as in the selection of its



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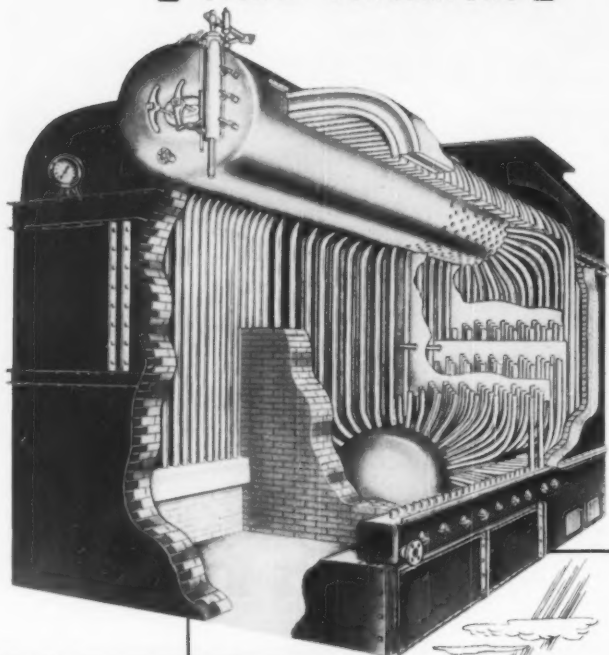
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architect and consultant. The engineer should be a regular member of the planning group and attend appropriate meetings of the building committee. When the job is finished the engineer should be placed on a retainer to inspect his plant semiannually and see that it is being properly operated and maintained. In my experience few if any hospital trustees or superintendents are in position to determine whether this is so or not.

The engineer should assemble in a scrapbook the manufacturers' printed directions for the operation and maintenance of each of the hundreds of pieces of equipment for the guidance of the operating force. Above all, when an engineer is retained to plan a hospital mechanical plant, he should inspect some of his previous jobs and some of the other fellow's, to see how they work, what equipment has proved unnecessary, and how it might have been done better.

A bill has been passed by the Senate, S. 614, which will make additional millions available for hospital construction and a million dollar fund for "research and studies of coordinated planning and integration of hospitals." If the A.S.H.V.E. could obtain a grant for engineering research I believe that much might be accomplished, not only for hospitals but for our entire heating economy.

My presentation has been that of a layman, from the consumer's cost angle. I would not recognize an engineering formula if I met it on the street. As George Ade said long ago, "I never laid an egg, but I'm a better judge of an omelet than any Plymouth Rock." With the millions to be spent for hospitals throughout the country, 30 per cent of which will go into mechanical plants, it is high time to review our procedures.

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LESSONS IN LAUNDRY MANAGEMENT—II

THE proper layout of a laundry is one of the major factors of efficient operation. Of late years the smart laundry operator has been increasingly conscious of the need for proper placement of machines and personnel. The executive housekeeper who is overseer of a laundry should make a study of this phase and should not hesitate to make necessary changes in accord with the following suggestions. Incidentally, these suggestions are not something I have dreamed up but are the result of intensive study at the American Institute of Laundering in Joliet, Ill., which is the national association of nearly all the commercial laundries in the United States as well as those of many hospitals and restaurants.

EVEN FLOW OF WORK

An even flow of work in step-to-step fashion with no back-tracking or bottlenecks should be the goal. There will be no hesitancy in picking the place where this work flow starts, for it can only be at the entrance of the soiled linen. The ideal situation would be to have it all come into the laundry through drop tubes but I realize this is almost impossible, because most institutional laundries seem to be an afterthought of architectural design. However it wouldn't hurt each housekeeper to look her institution over and see what the floor space directly over the washroom is used for. If it is at all possible this space should be commandeered and used for linen separation. Holes can be cut in the floor and metal hoppers installed into which the separated linen can be thrown until a specified weight is reached. This bin can then serve as storage space until the washman is ready to load his machine, at which time all that is needed is a tug on a rope connected with the hooks which hold the floor of the hopper up. When these hooks are dislodged the floor falls through and the work drops into the open washwheel which is located immediately under the hopper. Then the

JAMES R. BERRY
Assistant Manager
Old Colonies Laundry
Quincy, Mass.

floor can be swung up and connected with a spring latch ready to serve again as a sorting and storage bin. This loading of the machine only takes a matter of seconds and the soiled work is only handled once—in the separation room.

Contrast this method with the following which I feel sure is being done in most plants today. In making this contrast you will easily see why I urge you to commandeer space above the washroom. If the space above is not available then make sure the separation of linen is done right at the washroom to reduce the transportation to the minimum. This proximity of the separation or masking room, as it is called in commercial laundries, to the washroom is just as logical as it is for a restaurant to stack clean napkins near clean silverware.

When the soiled linen is separated it must be thrown into some form of movable box or truck. Because of the bulkiness of linen, such as sheets and tablecloths, the operator who does the separating will find it necessary to stop work several times to push the work more tightly into the box to make the required weight of work fit. This is necessary because boxes and trucks are limited in size; too large or bulky a box would create a traffic problem.

This is the second section of Mr. Berry's lecture on laundry management. In it he points out the importance of even work flow and suggests ways of achieving it. The third and concluding part of the laundry lecture will appear in May

The stopping of work in order to pack the load would not be necessary if the hopper system were available, for the latter is really a series of storage bins suspended in air, and because the bins are suspended they can be made large enough to hold the required weight without pushing.

When the box has been filled it must be pushed to the washwheel by someone, then loaded into the machine by hand, and the box pushed out of the washroom again to the girls who separate the soiled work. Consideration of these two methods shows the hopper has two big advantages, i.e. the time required to load the washwheel and the reduction of transportation of the clothes. Inasmuch as the sorting is done right over the washroom the loaded box does not have to be pushed so far to be emptied into the proper hopper.

SAME IN BOTH SYSTEMS

The unloading of the box would be the same in both systems, for it would take no longer to throw the work into the hopper than into the machine but the important thing is that the hopper can be filled while the washwheel below is still washing a previous load. There is no delay while the extractor baskets are pushed aside, the box loaded with soiled work is placed in front of the machine and the work is loaded into the wheel.

The institution can effect a saving of not less than five minutes to a load by installing the hopper system, and in a laundry that has several wheels these five minutes add up to approximately two additional loads a day from the washroom, or 600 pounds more work. Over a five-day week this equals 3000 pounds or more for the same amount of money paid out as labor cost, or productive labor. That should make your budget scanners happy.

It will be noticed that I am constantly reminding you of cost and budget. My purpose is to impress on you the need for study of the laundry;

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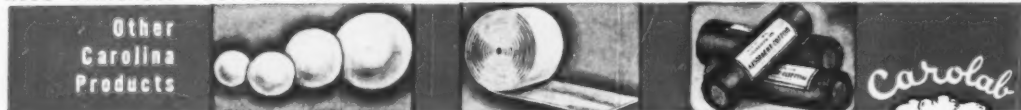
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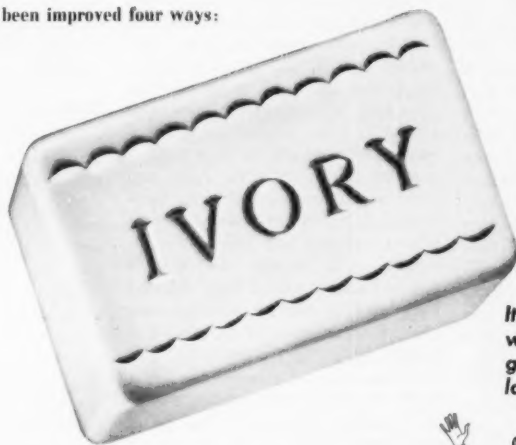


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too often, it is a sorely neglected place, only thought of when it runs a bit off schedule. As a result it is a haphazard conglomeration of inefficiencies and obsolete equipment. So if I can impress on you the close connection between money saving and laundry efficiency I will be satisfied.

Laundry requirements in a hotel and in a hospital are quite similar as regards the flatwork but quite divergent as regards personal wearing apparel. In a hospital various types of uniforms make up the bulk of the wearing apparel, most of which can be washed the same as the flatwork with a white work formula, and starched at the end of the wash. A hotel that does guest laundry meets many problems as regards classification which are foreign to the hospital.

ON INDIVIDUAL BASIS

Inasmuch as a guest bundle of laundry will consist of wearing apparel, the smooth work flow idea must be adhered to in the breakdown, dispatch, finishing, sorting and wrapping of each bundle, just as it must with flatwork except that it will be much more complicated. Instead of a mass production of linen for the stockroom there is the much slower production of small individual bundles, and they must be kept separate or headaches will ensue and heads will fall. There are many ways of handling this problem in commercial laundries and I am not going to attempt to name the best; however, I will present the two most popular methods and each housekeeper can make the various innovations and changes which are best adapted to the needs of her organization. Load breakdown, bundle size, contents of bundles, physical plant layout, and equipment vary so much from one laundry to another that it would be foolhardy of me to give you a word picture of the many innovations I have seen. These innovations do not alter the basic system but merely add to it because of some plant peculiarity. The two systems are: (1) pin and net, and (2) full identification.

System No. 1. The pin and net system means that everything in a bundle is put in a net and pinned with a large pin. Individual bundles are not mixed but are all separated and pinned up in separate nets. This, of course, calls for some suitable means of marking the net so that each of the bundles, nets and clothing can be

reassembled. Also, you must have a way of letting the tie-up girl know that she has the complete bundle. This can best be done by a series of numbered pins, sets made up of several pins of the same number, each attached to a bar with a key tag device so made that the pin will slide only on the proper bar and no other to minimize the possibility of mistakes.

Having all bars made with the same number of pins on them makes it apparent when the washed nets are reassembled and counted whether or not they are all present. Several pins of the same number are necessary on each because, even though the bundles will probably be small, still it must be remembered that all work cannot be washed together and you must provide a suitable means for keeping the various classifications together.

The following classifications should suffice for everything you will encounter: silks, wools, fugitives, lights and white work. You can, if you want, group the silks and wools together since they are washed the same way. However, I do not advocate it but would prefer to see these two classifications subdivided into light and dark and each netted separately. However if this does not fit in with your system and you can make only the separations of the silk and the wool I would rather see the light silk and light wool in one net and the dark silk and dark wool in another. The dyes in some silks are pretty bad, and this latter way of classifying gives a better chance of stain removal should it be necessary. Stripped down to its basic elements this is the pin and net system. Now let us look at the other method.

System No. 2 is the permanent or full identification. This is quite common in this section of the country and in Florida but in the rest of the country the pin and net system predominates. Full identification is just what the name implies: every item in a bundle is marked in a specified way, each bundle, of course, having a different mark. This mark is put on all the articles of clothing with an indelible ink which is readable even after as many as 24 washings. It is put on by machine or by pen and ink. The latter method, in my mind, is a neat and imposing way to mark but it results in lowered production and requires an adept person using the

pen. Even then her training period is quite long so in the long run the better bet would be a marking machine.

Another method of marking which came into prominence shortly before the war was widely advertised but not so widely used. This is called invisible marking, which merely means that the garments are marked with an ink which is invisible to the naked eye and can only be seen in a special light put out by the manufacturer.

The advantage is that a garment can be marked anywhere because the mark will not show and, as a result, production in the marking department should increase. This method has never caught on well with laundries, probably because anything so radically different is bound to be greeted with suspicion especially when it is going to cost money.

There are many variations and combinations of these two systems, so many that I am not going to attempt to explain them in detail or recommend any particular one.

CLASSIFYING COLORS, MATERIALS

Color and material classifications must be the same as those previously mentioned in the pin and net system, i.e. silks, wools, fugitives, lights and white work. Perhaps it will be well if I define the classification "fugitive" as meaning some color which is likely to run or some article which is exceedingly grimy. The term "light" means some colored article which is quite fast but would be harmed by the addition of bleach to the wheel in which it is being washed.

Laundries in both hospitals and hotels also will be expected to handle such special items as blankets, curtains, rugs and chair covers. These too must be routed through the plant in an even flow in conjunction with the regular work. I do not believe that any of these lend themselves readily to the pin and net system of identification but the decision on that must be left to the individual housekeeper.

We will take leave of the marking room but before doing so I must reiterate that the backbone of the entire even work flow is right there and the efficiency of the work flow depends to a great extent on how efficiently you regulate this room. You should see to it that you have an ample supply of linen; take an average of the linen used during a specified number of weeks, and then break this down

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into five working days. Then plan on doing a predetermined amount of work each day with only minor fluctuations. If you have sufficient inventory you can hold back some of the soiled linen which almost invariably flows into the laundry on a Monday until a later period in the week when the demand diminishes. In this way you avoid a situation where poorly washed, poorly ironed work is put out by disgruntled employees who feel you are an incompetent supervisor because you give them too much to do at some times and too little at others.

This proportioning of work is the only reasonable and logical method for a thinking person to consider for it assures a uniform quality, enables you to staff your plant properly with an adequate number of employees who have enough work to do to give you 60 minutes' labor for every 60 minutes' pay you give them. They do not spend hours waiting around at your expense for something to do because you have been forced to overstaff the plant to meet the Monday and Tuesday backbreaking loads. If you object to having such a large inventory I will concede that the initial cost will be tremendous but, after all, it is not money thrown away, merely premature spending in anticipation of greater gains later on. Labor is the most costly commodity on the market today, and inasmuch as proportioned work can be a means of cutting down on this commodity there should be no objection to your doing everything in your power to eliminate labor.

Remember at the outbreak of the last war during the gasoline shortage when route delivery men were put on a staggered schedule, people who for years had been accustomed to having fresh milk at their door early each morning could not see how they would manage when milk was delivered only every other day. The war and gas rationing are over and now these same people are sold on the idea and take it for granted as a means of keeping the cost of milk down by cutting the delivery expense.

The same holds true in the laundry business. When I started, the laundry was picked up and delivered the same week, and being just one day late was enough to bring severe reprimands from irate customers. It seemed that none of our customers had enough linen to last more than three days nor could they see any reason to have such an inventory even if they could afford it. Then they too were put on a weekly basis and found they could go a week without their laundry and that they could afford a greater inventory. Now the housewife is sold on the idea, for instead of having to think about the laundry twice a week, her worries have been cut in half; she now thinks of laundry only once a week. Surely any system that cuts your worries down is worth while.

These examples can well be applied to your situation, for no doubt some of you have the feeling that you must have all the week-end soiled linen cleaned up on Monday or Tuesday noon at the latest, and as a result add extra personnel to your plant. With sufficient inventory you don't have to

have this work before the next weekend and so cut out that extra labor. Try this system and see if it doesn't soon grow on you. Perhaps this increased inventory is foreign to everything you have ever seen or practiced. However, if you can put the idea across to your superiors you can sit back and enjoy the return of your investment month after month. You will know that for every dollar you are paying labor in the laundry you are getting one dollar's worth of work, not 85 per cent work and 15 per cent waiting for work. This alone, not to mention the fact that fewer employees will be needed, is a margin of return that any businessman should eagerly grasp.

Now after this rather lengthy digression let us get back to the marking room and even work flow. For the sake of clarity I will give you several goals compiled by A.L.I. production methods engineers:

1. Identification must be used for scheduling the work through the plant and should be so controlled that all types and classifications, as well as specials, are ready for the washroom and the finishing departments as they are needed with no lost labor time waiting for work.

2. The identification work should be done in any orderly way that will reduce the handling to a minimum, for a "pick it up—put it down plant" will soon be a bankrupt plant. Also, soiled laundry is much easier to handle when it is dry than when it is wet, so all necessary steps and handling should, to a great degree, be done at this point.

3. It is an axiom of the trade that one should never have more than one hour's work ahead of any machine; if this is to be accomplished the control must be exercised at the start. Too much work ahead of any machine means a need for floor space for storage and the average institutional laundry has little enough space as it is.

4. Machines have a capacity for just so much work per hour or day, be they washwheels, ironers or presses; any well run identification department must take into consideration the capacity of the machines.

These are the goals to strive for and now, as regards the ink used in marking, I suggest you buy the best available, for in the long run it will be the cheapest in that it will stay readable longer and can stand many more washings.

WRITE FOR YOUR VOLUME INDEX

If you bind your volumes of *The Modern Hospital* you will want the index to volume 73, covering issues from July through December 1949. You may obtain your free copy by writing to *The Modern Hospital* at 919 North Michigan Avenue, Chicago 11, Illinois.

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PERSONNEL HEALTH SERVICE

(Continued From Page 64.)

ness has apparently been due to communicable disease, or if he appears ill, the nurse should see to it that he is examined.

AFTERNOON CLINIC

The afternoon clinic is held for the examination of the ambulatory sick, for the examination of those returning after illness, and for those requesting medical consultation. This clinic might well begin about 12:30 (for those who eat between 12 and 1 o'clock) and extend through 2 or 2:30 (to include those who eat between 1 and 2). These hours probably interfere the least with the employee and the working of the department, and therefore will meet with the fewest objections from both department head and employee; also they will attract the largest number of patients. This latter is an important factor since examination in the early stage of illness is the ideal striven for in all preventive work as being best for employee, patient and hospital.

The assistant medical resident who usually is the one in charge of this clinic refers those patients needing hospitalization to the hospital, those requiring further study to the personnel health clinic on the following day, and takes care of all minor illnesses himself.

EMERGENCY CARE

Illnesses or injuries arising outside of clinic hours are cared for in the emergency room by the regularly assigned house officers who render the usual emergency care, admit the patient to the hospital when necessary, and refer others to the personnel health clinic.

Most injuries for which employees report to the emergency room fall within the realm of workmen's compensation, and the house officers must therefore report them immediately to the administration. These patients are also referred to the personnel health clinic on the following day for such care or disposition as the physician may then decide on.

HOSPITALIZATION

In those hospitals with dormitories patients who are too ill to come to clinic must be examined in their rooms by the personnel physician. Unless the patient need be confined to his room for only a few days, immediate hospitalization should be provided; furthermore, the patient should be permitted to remain in his room only if toilet facilities are close at hand and the necessary arrangements for food can be made. Patients requiring nursing attention should not be permitted to remain in their rooms. Since most of these nonhospitalized patients will have upper respiratory infections, it is not only wise but essential that such employees be permitted to remain in their rooms only if they occupy single rooms.

Patients who are too ill to remain in the dormitory, and, in institutions which have no dormitories, those who are too ill to remain at home must be hospitalized. The accommodations will, of course, depend on several factors: what the hospital policy is; whether the patient has voluntary hospitalization insurance; whether he can afford to pay for private facilities, and, not the least important, how ill he is.

It has generally been found inadvisable for the personnel physician to go outside the hospital to care for any employee no matter how near or how far from the hospital he may live.

DENTAL SERVICE

The dental service offered to employees should be at least as complete as that offered to the general clinic public and may thus range from extractions only to complete dental care, including the provision of prostheses.

Whether or not the employee is to be charged for the more expensive dental work should depend completely upon his ability to pay, this being judged in a manner identical with that in which the regular clinic patient's ability to pay is judged.

Charges for such work should be the same for both the general clinic public and the employee; they will almost invariably be at or below cost level.

SOCIAL SERVICE

The extent to which the social service department will cooperate with the personnel health service will depend on the policy of the hospital. Counseling of the healthy employee with social problems is outside the province of medical social work as practiced today,

and many departments will therefore prefer not to do it, although they will certainly listen to the employee's problem and refer him to that agency in the community best able to help him in his specific difficulty. Others already do such counseling on an unofficial basis since they would rather not take it on as an admitted part of the service they render because of a fear that it may increase their case load beyond their capacity.

Service to the sick employee is a different story, for the basis of medical social service is the medical need of the patient, which may be aggravated by social conditions and may require social as well as medical treatment.

It is obvious that even within these limits the social service department can frequently be of invaluable assistance to the personnel physician, working with him as it does with other physicians in the wards, in the private pavilion, or the outpatient department.

The cooperation between social service department and the personnel health service will not only contribute to the restoration and maintenance of health of the sick employees, but also immeasurably improve the relationship between the hospital and its personnel.

SPECIAL PROBLEMS

WORKMEN'S COMPENSATION

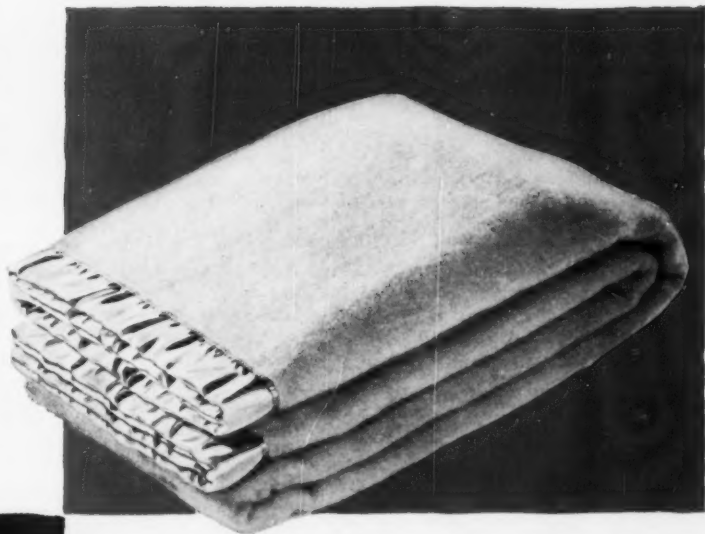
The personnel health service, as outlined here, will be concerned with all injuries arising in the line of duty, as well as with occupational and non-occupational diseases.

It has already been suggested that injured employees report immediately to the emergency room for treatment, and that the house officer on duty there report the accident in writing to the administration. He should do this on a special form which contains spaces for the answers to all pertinent questions so that the accident may be promptly and correctly reported in accordance with state law.

The patient is referred routinely by the house officer to the personnel health clinic on the day after the accident. The personnel physician then assumes complete responsibility for the care of the patient even though he may call on consultants for assistance, and it is he who completes all subsequent medical reports.

When first meeting a medical problem with a compensation aspect the personnel physician often asks what the law says.

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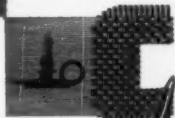
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The law answers no medical questions. The medical aspects of the problem are wholly within the province of the physician, and it is thus up to the physician to say whether a disease or an injury is occupational. This is simply a question of fact. Often the answer is obvious; sometimes it is difficult. But physicians, and only physicians, should decide whether an injury or a disease is occupational.

If the answer is "Yes, the injury or the disease is occupational," another question arises and that is "Is the injury or the disease compensable?" The

answer to this question is a legal one, for the basic determining fact here is the jurisdiction in which the accident occurs. For example, some states exclude domestic personnel; others exclude farm labor; still others apply their laws only when the employer has more than a certain minimum number of employees, and so on.

TUBERCULOSIS

Of the many problems which will present themselves frequently to the personnel physician tuberculosis is probably one of the commonest:

1. In the preemployment examination, the physician may discover an employee with active tuberculosis, questionably active tuberculosis, or inactive tuberculosis.

2. During the periodic routine checkup, the physician may discover an employee who, in the year intervening between the previous examination and the present, has developed suspicious changes or even positive evidence of tuberculosis.

3. The personnel health physician may discover tuberculosis during an examination made for another purpose.

What is to be done with employees who have either inactive or questionably active tuberculous lesions can only be determined by the medical staff. The physician in charge of the chest service should set down in writing the basic principles to be followed by the personnel physician. This, however, does not alter the fact that each case must be judged individually; that each employee must be considered not only as an individual but also as an employee in relation to the work he is to do, and as a member of a society to any of the members of which he may transmit his disease.

VENEREAL DISEASE

Not only industries but hospitals have been guilty of denying employment to applicants because of venereal disease. Both have forgotten that the worker with venereal disease is no different from any other person who requires an income and who must have a place in society; both have not sufficiently realized that society has only prejudice as a reason for making an outcast of a syphilitic. This attitude is medically indefensible for there is no reason for discriminating against persons serving as food handlers solely, for example, on the basis of their having a positive sero-diagnostic test for syphilis.

Whenever the disease is infectious, employment should be delayed or interrupted until such a time as a non-infectious state is established through treatment.

When syphilis exists in the latent stage employment should not be delayed but treatment should be given. The applicant must not, however, be employed unless he agrees to adequate treatment. Whenever the worker becomes delinquent in treatment without just and sufficient cause and whenever, despite the usual follow-up by the epidemiologist, he refuses to continue



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appropriate therapy he can be made subject to dismissal.

When disabling manifestations of syphilis exist which render such persons industrial hazards to themselves, to patients, or to other employes, employment may have to be denied. Employes with such disabling manifestations may be able, however, to perform some useful type of work in the hospital and provision should be made, if at all possible, for the occupational readjustment of these employes.

"EPILEPSY"

Here, again, employers have been

guilty of denying employment because of (putting it most charitably) such misconceptions as that "epileptics" are mentally and physically defective, that the seizures are "horrible to see" and that hard work is harmful. All these are incorrect. Most "epileptics" have been found unusually willing and faithful, eager to work and to prove acceptable.

The occupations generally regarded as "unsuitable" for these workers have been grouped by Lennox and Cobb into three classes:

1. Those categorically forbidden be-

cause the lives of others might be endangered: (a) operation of automobiles, streetcars, elevators and locomotives, and (b) positions of intense personal responsibility, such as suture nurse in major surgery, or swimming instructor.

2. The operation of machinery of such a nature or work at such a height that temporary loss of consciousness might injure the patient or the machine: house painting, machine tool operator, stationary engineer.

3. Prohibitions which arise from popular reactions and prejudices. In this group the number of eyes focused on the person is the controlling factor—the stage, the concert and lecture platform are examples.

But in all cases advice must be fitted to the individual for there are many factors to be weighed here, (this is the art of job placement!). At no time should an individual with "epilepsy" be categorically refused any work in a hospital.

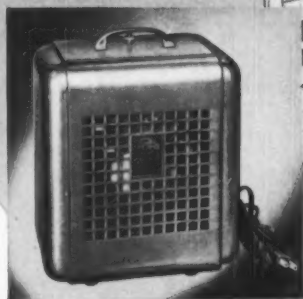
HEART DISEASE

Whether or not to employ an individual with a heart disease depends completely upon his medical status. There is no reason whatever for not employing, or for discharging, an employe with asymptomatic heart disease or asymptomatic hypertension. Nor is there any reason for refusing to employ, or for discharging, an employe with either of these two diseases even when severe if the job does not tax or overtax the individual.

PSYCHIATRY

The personnel physician in the hospital, dealing as he does with everyone from the director to the porter, will find himself dealing with every form of psychiatric problem. He will find it necessary to weed out the obviously psychotic, the obviously mentally subnormal, the psychopathic, and even some of the borderline personalities as well as certain syphilitics, some alcoholics, and some "epileptics." He will find, too, that many of those already employed present psychiatric difficulties requiring treatment. But the personnel physician can hope only to practice selective and a minimum of preventive psychiatry, for the chances are that he will have neither the training nor the time to practice any more. He will, therefore, refer all patients requiring treatment to the proper consultants, using the psychiatric service of the hospital as he would the allergy, surgical, or social service departments.

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NEWS DIGEST

Ruby Gilbert Named President-Elect of Texas Association . . . Blue Cross, Steel Companies Sign Contracts . . . New York Council Analyzes Ginsberg Study . . . "Fortune" Article Lauds Ives-Flanders Health Bill

800 Delegates Attend Texas Meeting; Ruby Gilbert Is President-Elect

GALVESTON, TEX.—The nation's hospitals owe approximately 27 per cent of all their patient income to Blue Cross, yet Blue Cross subscribers number only 23 per cent of the nation's population, Dr. Paul R. Hawley, director of the American College of Surgeons and former Blue Cross-Blue Shield chief, declared in one of the major addresses at the 21st annual convention of the Texas Hospital Association here last month. These figures mean that Blue Cross subscribers are taking advantage of their insurance to go to the hospital when it may not be necessary and to remain in the hospital longer than is needed, Dr. Hawley said.

The disproportionate revenue coming from Blue Cross also reflects the fact that attending physicians are likely to order unnecessary drugs, tests and other procedures for Blue Cross patients, he added. These practices can drive Blue Cross subscription rates up to a point beyond the average family's ability to pay. Dr. Hawley warned, and thus threaten the economic security of the voluntary hospital system. When Blue Cross becomes too expensive for low and middle income groups, we will have socialized medicine, he concluded.

Dr. Hawley addressed more than 800 delegates who came here for the annual hospital convention. Meeting concurrently with the hospital group were the Texas Association of Nurse Anesthetists, the Texas chapter of the American Association of Medical Record Librarians



Ruby Gilbert

and the Texas Association of Hospital Auxiliaries.

Ruby B. Gilbert, administrator of King's Daughters' Hospital at Temple, was named president-elect of the hospital association. Mrs. Gilbert will succeed Roy Wilmesmeier, administrator of the Southern Pacific Hospital at Houston, who became president during the convention. Mr. Wilmesmeier took over the office from Julian H. Pace, administrator of the Hillcrest Memorial Hospital, Waco.

In another convention address, Philip R. Overton of Austin, association attorney, blasted federal aid for hospitals in any form as a step toward socialism. "The social security program is the most damnable project ever set up by a government," he declared. "The only secure persons in this country today are in the insane asylums and jails, and they are



At the A.C.H.A. luncheon during the Texas meeting: Frank Walter, Mrs. Josie Roberts, George Bugbee and Julian H. Pace.

secure only if they are in for long terms! When we receive anything from the federal government we are cutting our own throat."

Federal taxes are already so high that hospitals have suffered the loss of philanthropic aid, Mr. Overton pointed out. Taxes must be cut down, he said. "Let's get back to a firm foundation. We can't

(Continued on Page 152.)

Blue Cross, Steel Companies Sign Contracts Covering Approximately 900,000

PITTSBURGH. — Hospital Service Association here has completed contracts for Blue Cross hospitalization coverage of employees of the United States Steel Corporation, Jones & Laughlin Steel Corporation, Sharon Steel Corporation and numerous other smaller steel companies, it was announced last month. Together with the recently signed Bethlehem Steel Corporation coverage, these contracts provide Blue Cross protection for approximately 900,000 persons.

The Blue Cross program is part of the insurance benefits agreement between the steel companies and the United Steelworkers of America, it was explained. The union and the companies have approved the Blue Cross program, the cost of which is to be shared by the employees and the companies.

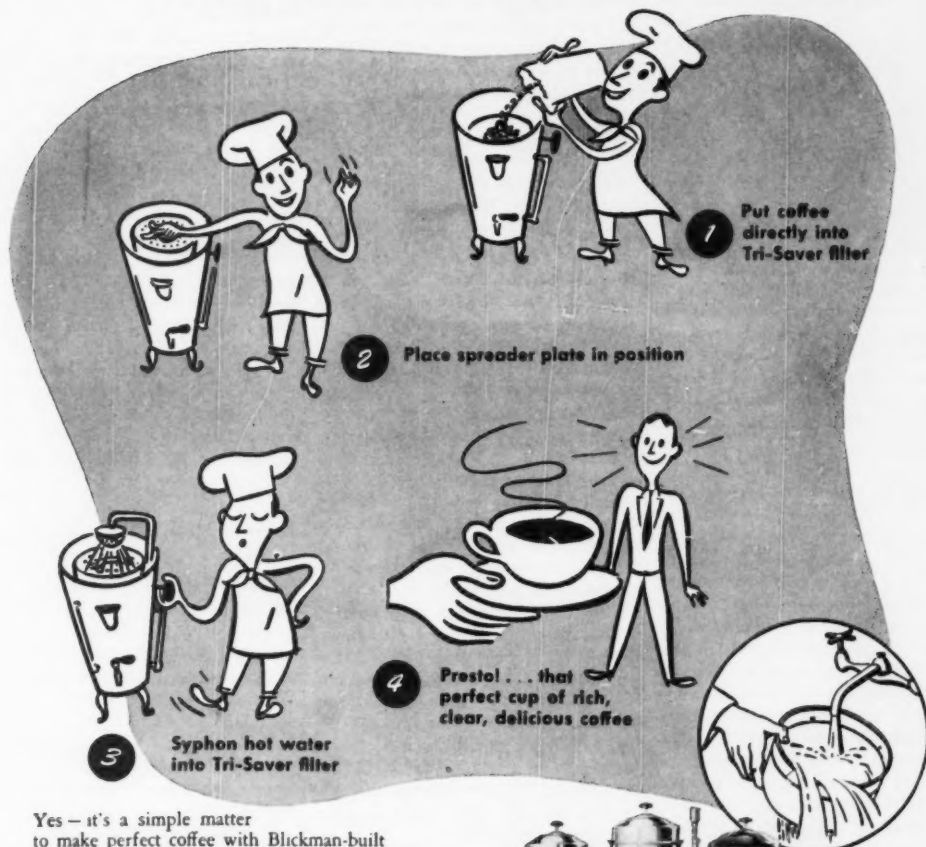
The hospitalization program offers coast-to-coast coverage for employees of the steel corporations through an interplan arrangement linking together the Blue Cross offices throughout the country wherever the companies have plants or offices.

Dr. Paul R. Hawley, former chief executive officer of the Blue Cross and Blue Shield commissions, described the steel contracts as "the greatest contribution ever made to Blue Cross." Abraham Oseroff, vice president and secretary of the Pittsburgh Hospital Service Association, said that hospitalization was the heart of the social benefits program. "Hospitalization is by far the most frequently and most extensively used service in industry's social benefits plan," Mr. Oseroff said. "So the type of service selected should be the best available. We feel that the arrangement with the steel industry and United Steelworkers is a ringing endorsement of Blue Cross."

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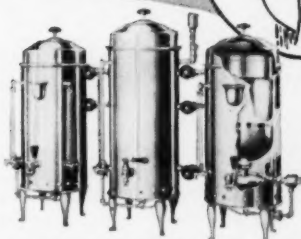
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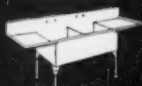
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Visit us also at our exhibit at the National Restaurant Show, Navy Pier, Booths No. 723-726, Chicago, Ill., May 23-26

NEWS...

New York Council Issues Analysis of Hospital Study Made by Eli Ginsberg

NEW YORK. — In a statement released here last month, the Hospital Council of Greater New York expressed agreement with many of the aims set forth in the report of the New York State Hospital Study, recently published by Prof. Eli Ginsberg of Columbia University and his staff, but added that it "cannot go all the way with Professor Ginsberg" in his decisions.

"We share Professor Ginsberg's concern for a larger volume of services for ambulatory patients, for the planning of hospital facilities and services in the interest of the community, for the raising of standards of care, and for the coordination of voluntary and governmental efforts," the council stated. "In a number of areas, however, especially in assessing the quality of care, the report tends to accept things as they are, with perhaps too little consideration of needs and possibilities for expansion and improvement."

The council approved the report's emphasis on voluntary insurance and states that "Prepaid insurance is good for the hospitals, it is good for the consumer, and it is also good for government," but took strong issue on one point. "Professor Ginsberg estimates that by the end of 1953 more than 75 per cent of the population of the state will be enrolled in voluntary hospitalization insurance plans. In his opinion, this would constitute satisfactory progress toward his defined goal of 85 per cent coverage. Should a smaller gain take place, however, he would proclaim voluntary insurance a failure and resort to compulsory insurance as the only possible alternative. We disagree. Professor Ginsberg's seems to be a position of all or nothing.

"Our position is that as many people as can afford to pay the premium ought to be enrolled," the council stated. "This means an earnest endeavor to educate consumers to change their patterns of expenditure. It entails the employment of all available technics for public support of voluntary hospitalization insurance. After this has been done for several years, the situation will be ripe for review. At that time all reasonable alternatives should be considered."

The hospital council considered Professor Ginsberg's caution in assessing requirements for the expansion of general

hospital beds justified. It added, however, "In planning hospital facilities, the exact number of beds estimated according to the best available formula is not too significant. The important point is that a planning organization should be in continual operation. Such an organization would be in a position to guide the implementation of its plans. As conditions change, it might wish to accelerate construction, retard construction, or to stop it altogether."

William S. McNary Named Blue Cross Chairman

CHICAGO. — William S. McNary, executive vice president of Michigan Hospital Service, Detroit, was elected chairman of the Blue Cross Commission at the commission meeting held last month in Montreal following the annual conference of Blue Cross plans, it was announced at commission headquarters here. He succeeds J. D. Colman, executive director of Maryland Hospital Service, Baltimore.

Louis H. Pink, president of Associated Hospital Service, New York, was re-elected vice chairman, and Abraham Oseroff, vice president of Pittsburgh Hospital Service Association, was re-elected commission treasurer.

Leon R. Wheeler, executive secretary, Associated Hospital Service, Milwaukee; J. Philo Nelson, executive director, Hospital Service of California, Oakland, and Carl M. Metzger, executive director, Hospital Service Corporation of Western New York, Buffalo, were elected to the commission to succeed F. P. G. Lattner, Des Moines, Iowa; Ralph G. Walker, Los Angeles, and Robert E. Johnson, Jamestown, N.Y.

Dr. W. B. Seymour, director, University Hospitals of Cleveland, was named to serve on the commission as one of the three representatives of the American Hospital Association, replacing Oliver G. Pratt, director, Rhode Island General Hospital, Providence.

Nearly 36,000,000 persons in the United States and Canada were enrolled in Blue Cross plans on Dec. 31, 1949, Richard M. Jones, commission director, reported. Total net gain in Blue Cross enrollment for 1949 was 3,144,356. Mr. Jones indicated that 23 per cent of the population of the United States and 20 per cent of the population of Canada were enrolled in Blue Cross at the close of 1949.

New England Hospital Program Offers "Day-to-Day" Help for Delegates

BOSTON. — More than 4000 representatives of New England hospitals met here at the 27th annual New England Hospital Assembly March 27 to 29. The three-day conference was devoted to all phases of hospital operation. Lester E. Richwagen, director of Mary Fletcher Hospital, Burlington, Vt., and president of the assembly, said its purpose was "to provide administrators, trustees, doctors, nurses and staff members of our 500 New England hospitals, infirmaries, clinics and other institutions with a program that can be helpful to them in their day-to-day jobs."

Among those who addressed the assembly were Dr. Gerald F. Houser, director of Faulkner Hospital, Jamaica Plain; Dr. Dean A. Clark, director of Massachusetts General Hospital; Dr. Frank R. Bradley, Barnes Hospital, St. Louis, and John H. Crider, editor of the *Boston Herald*. Paul J. Spencer, Lowell General Hospital, Lowell, Mass., was chairman of the program committee.

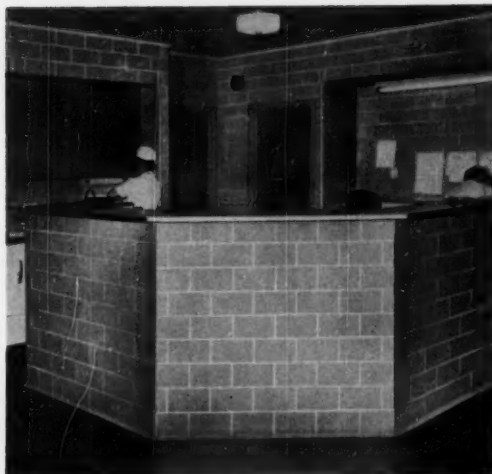
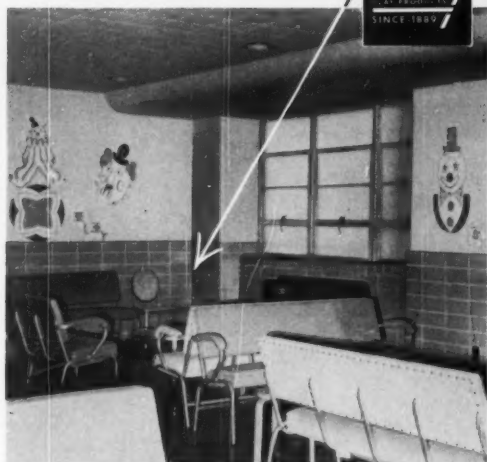
New Section at Tri-State to Study Institutional Care of Chronically Ill

CHICAGO. — More than 6000 administrators, physicians, trustees, nurses and other hospital workers are expected to attend the twentieth annual Tri-State Hospital Assembly here May 1, 2 and 3, according to Dr. Malcolm T. MacEachern, chairman of the assembly and director emeritus of the American College of Surgeons. A new section meeting as part of the assembly this year will study institutional care of the chronically ill. The section is under the direction of Edna Nicholson, director of the Central Service for the Chronically Ill, it was announced.

A program to provide the greatest possible help to hospital administrators and public relations directors has been planned by the Chicago Hospital Public Relations Association for the public relations section, the association reported last month. Speakers include Grant Adams, public relations director of the Michael Reese Hospital; Eva H. Erickson, administrator of Cottage Hospital, Galesburg, Ill.; Scott Jones, public relations director of Wesley Memorial Hospital, and Karin Walsh, city editor of the *Chicago Sun-Times*.

Walls

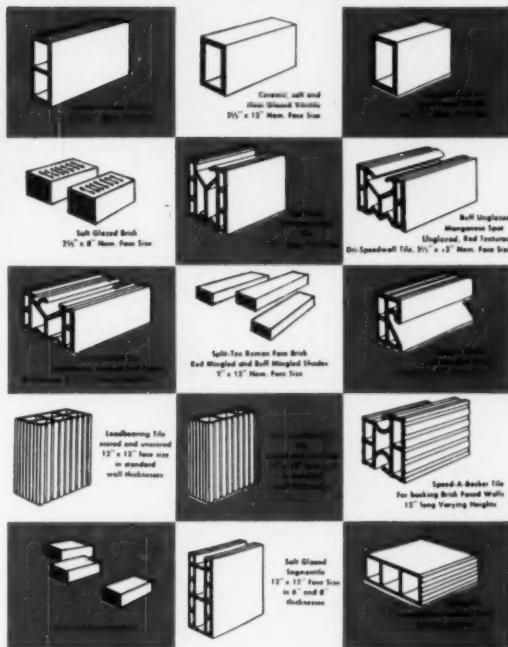
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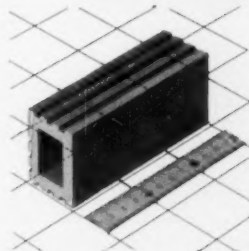
Natco Structural Facing Tile was used (above) in the Nurses' Station and (at left) in the Waiting Room of the Children's Hospital, Akron, Ohio. Architects—Wagner and Luxmore. General Contractor—Carmichael Construction Co.

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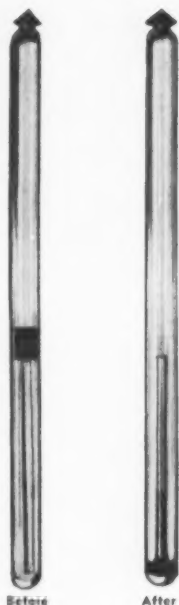


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NEWS...

Ives-Flanders Health Bill Lauded by Davenport in "Fortune" Article

NEW YORK.—The health insurance legislation sponsored by Senators Ives of New York and Flanders of Vermont and Representatives Auchincloss and Case of New Jersey, Javits of New York, Herter of Massachusetts, and others (S. 1970 and H.R. 4919) was described in detail and lauded as a program that meets the nation's health needs without sacrificing initiative to the federal government in an article by Russell W. Davenport appearing in *Fortune* magazine for March.

"The administration plan gives the initiative to the government," the author stated. "The Republican plan, while providing government aid, gives initiative to the people themselves."

Reviewing health facilities and needs, the article concluded that it is "unrealistic" to view present facilities and personnel as adequate. "The truth is that some portion of the American people—no one knows exactly the number—can and do get the best medical care in the world," Mr. Davenport stated. "But another portion get this kind of care only when they are lucky, or if they make a tremendous financial sacrifice; while still a third portion do not get it at all. And the disconcerting fact seems to be that the second and third groups, added together, constitute more than half the population."

"Generally speaking, therefore, it can be said that the medical services of the U.S., while adequate, or nearly so, in certain wealthy areas of the country, fall in other areas far below any standard that an American could conscientiously defend."

Reasoning that the health insurance principle must be extended to cover all or nearly all the population before this situation can be permanently improved, Mr. Davenport described the Ives-Flanders legislation, which would provide federal loans to voluntary nonprofit health insurance plans whose members would be enrolled on a percentage of income basis, as "a remarkable proposal based on the voluntary principle" which "seeks the achievement of an important social goal in a uniquely American manner."

Answering the criticism that the Ives-Flanders plan would subsidize the high costs of voluntary plans, including collection and sales promotion costs, the

article said that sales promotion would constitute a form of medical education and that "the additional cost of voluntary programs, if any, represent the cost of free choice."

"The ultimate question, therefore, is whether the American people have got the initiative and the intelligence to subscribe to voluntary health plans," Mr. Davenport concluded. "Administration supporters do not think so. The Republicans, on the other hand . . . merely say that nobody knows because nobody has really tried. . . . The Progressive Republicans believe that the hope of freedom lies in the intelligence of individuals of which our society is composed. They desire to test this proposition before surrendering it, and they maintain that the medical issue, which now faces the nation, provides almost a perfect test."

Alabama Elects Officers

MONTGOMERY, ALA. — D. O. McClusky, administrator of Druid City Hospital at Tuscaloosa, was elected president of the Alabama Hospital Association.



Mrs. Jewell W. Thrasher, Dothan, congratulates D. O. McClusky, who was elected president of the Alabama Hospital Association.

tion at the 29th annual meeting of the association here last month. Other officers elected were: first vice president, Gertrude Pratt of Huntsville; second vice president, J. H. Hargon, Birmingham; secretary, C. L. Sibley of Birmingham, and, treasurer, E. E. Cavaleri Jr. of Birmingham.

Auxiliary Has \$7000 Project

MINEOLA, N.Y. — Members of the women's auxiliary of the Nassau Hospital here have adopted a \$7000 project for the coming year. This will provide the hospital with autoclaves for its central supply service, oxygen equipment, carriers, positive pressure units and gauges, photomicrographic apparatus and stainless metal cabinets for cracked ice for each nursing unit. Mrs. Edwin L. Smart of Rockville Centre, N.Y., is the new president.



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BEDFORD COUNTY MEMORIAL HOSPITAL Bedford, Pa.	595,000	648,011	APRIL, MAY, JUNE, JULY
POTSDAM HOSPITAL Potsdam, N. Y.	200,000	195,142	JUNE, JULY, AUGUST
NEW CASTLE HOSPITAL New Castle, Pa.	595,000	679,266	APRIL, MAY, JUNE, JULY
OSWEGO HOSPITAL Oswego, N. Y.	600,000	832,829	JUNE, JULY, AUGUST, SEPT.

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NEWS...

Protestant Hospital Groups Meet in Chicago

(Continued from Page 70.)

welcome free competition as a normal part of the democratic processes.

Dr. Bradley proposed an integrated group practice system based on the hospital, with doctor and hospital sharing the income and expenses. "The hospital is becoming the center of medical care," he reminded his hearers. "This is inevitable, because it seems that our mode of living forces concentration of funds

and service facilities. Group practice is one arrangement which will improve medical practice and lower its unit cost, for the reason that it is susceptible to and can use the volume basis of operation."

Dr. Bradley also warned against the possible "federal monopoly" of hospital facilities that might result from unrestricted expansion of the Veterans Administration hospital program.

Other features of the program were a demonstration hospital board meeting



Salvation Army officers in attendance at Protestant Hospital Association session.

presented by students in the hospital administration program at Northwestern University and talks by members of the hospital chaplains' section of the A.P.H.A. In the final evening meeting Roy Johnson, hospital decorating authority, discussed the effects of the hospital environment on both patients and employees.

In addition to Mr. Lyons and Dr. MacEachern, officers elected by the association were: first vice president, John G. Dudley, Houston; 2d vice president, Lee S. Lanpher, Cleveland; treasurer, Rev. L. B. Benson, Minneapolis; trustees, Robert Neff, Indianapolis; F. A. Hanson, Des Moines; Lt. Col. Florence Turkington of the Salvation Army, and Rev. L. B. Benson, Minneapolis.

Hospital Building Program Totals Half Billion Dollars

WASHINGTON, D.C. — A half billion dollars' worth of hospital and health center construction has been approved for government aid under Public Law 725 in the last two years, according to a report released last month by the Hospital Facilities Division, U.S. Public Health Service. In addition to federal funds, this sum includes funds provided by states, local communities, and private organizations, the report said.

Projects cleared by the Public Health Service over this period totaled 1019 hospitals and health centers. They received a total of \$210,000,000 in federal funds. The first hospital approved for federal aid under the National Hospital Program was at Langdale, Ala., in November 1948. Today 139 are in operation, 523 under construction and 357 approved initially but still in the blueprint stage.

Mississippi leads the nation with 83 projects approved, nine of which are completed, it was reported; Georgia has 66 and Texas and South Carolina have 64 each.



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NEWS...

Annual Conference of Methodist Board

(Continued from Page 70.)

Methodist Hospital at Houston, Tex., succeeded Dr. O. J. Carder of St. Joseph, Mo., as president of the association, and Neal D. Ireland, director of the Pacific Home for the Aged, Los Angeles, was named president-elect. Three persons who have made outstanding contributions to hospitals and homes were named to membership in the Methodist Hall of Fame in Philanthropy. Those honored were: A. H. Blank of Des Moines,

Iowa, benefactor of the Iowa Methodist Hospital and the Raymond Blank Memorial Hospital for Children at Des Moines; Franklin N. Kornhaus, Oakland, Calif., for his many years of service as an official and member of the board of the Fred Finch Children's Home in Oakland; Judge Alfred K. Nippert, Cincinnati, for 25 years trustee president of the Elizabeth Gamble Deaconess Home Association and Christ Hospital and long-time board member of Bethesda Hospital and Deaconess Association.

In conferences of the Methodist hospital group, speakers discussed several aspects of modern hospital operation. The need for accurate financial records and accounts was stressed in one discussion by Marshall I. Pickens, associate director of the Duke Endowment. He described the reporting system used by hospitals affiliated with the Duke Foundation, which is designed to provide comparability of reports so that hospitals can measure their results against the achievements of others. This system tends to make the best practices in each hospital available to all the other hospitals, Mr. Pickens said. He gave a number of examples of how this has worked out in various hospital departments.

Donald Cordes, Iowa Methodist Hospital, Des Moines, discussed the many factors involved in keeping hospital workers contented and productive. Emphasis on good human relations and the selection and training of properly qualified supervisory personnel is essential, Mr. Cordes said. He urged administrators to consult supervisors and department heads before making policy decisions affecting personnel.

At a luncheon meeting of the hospital group, Rev. Carroll A. Wise, professor of pastoral psychology and counseling at Garrett Biblical Institute, Evanston, Ill., emphasized the emotional and spiritual needs of the hospital patient. A well trained hospital chaplain can help doctors and nurses solve many of those problems relating to the patient's illness, he said, and thus speed recovery. However, ministers must have special training before they can serve effectively in the hospital, Dr. Wise warned.

In addition to Mr. Ireland and Mrs. Roberts, officers elected by the Methodist Association were: vice presidents: Rev. Harold R. Barnes, Oakland, Calif., Milo Anderson, Gary, Ind., Rev. L. S. Moore, Philadelphia, and Rev. B. W. Selin, Chicago; secretary, Margaret Brooks, Lake Bluff, Ill.; treasurer, Mary V. Stafford, Milwaukee.

Baptists Vote Down Federal Aid

CHICAGO.—At a meeting held concurrently with the Methodist convention in advance of the convention of the American Protestant Hospital Association here, members of the Southwide



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NEWS...

Baptist Hospital Association repudiated all forms of government financial aid for hospital construction and operation. The strongly worded resolution approved by the Baptist group described acceptance and use of government funds by a religious denomination or society as "encouragement of the present trend in America toward a socialized state."

The association declared itself as opposed to any "gift, grant or allocation of tax funds to any religious or sectarian denomination or society by the federal government or any political subdivision thereof to be used for the building and operation of hospitals by said religious or sectarian denomination or society."

Opposition of the Baptist group to government aid for hospital operation or construction was based on the belief that religious hospitals are organized for the purpose of propagating religious teachings as well as to provide care for the sick and that government aid was therefore a violation of the American belief in separation of church and state, it was explained. "We believe the allocation, grant or gift of tax funds by the federal government or any political subdivision thereof to a religious or sectarian organization, denomination or society for the purpose of constructing, equipping or operating a hospital is in violation of the First Amendment to the Constitution of the United States," the Baptist resolution stated.

Institute for Engineers

CHICAGO.—An institute for hospital engineers will be conducted by the American Hospital Association at St. Louis, April 24 to 28, Roy Hudenberg, secretary of the association's council on hospital planning and plant operation, announced last month. The purpose of the institute is to provide engineers with information concerning new developments in hospital plant operation and maintenance, to develop means for trading information on practical methods, and to provide hospital background for engineers new to the field.

Construct Maternity Pavilion

NEW YORK.—Construction was undertaken here last month on a new 10 story maternity pavilion at Mount Sinai Hospital. The unit is part of a \$7,000,000 expansion program that will also add research laboratories and new service facilities, it was announced.



Architects: Curtin & Riley, Boston

BETH ISRAEL HOSPITAL
Boston, Mass.

Charles F. Wilensky, M.D., Director
and President-elect of the
American Hospital Association

- One of New England's outstanding hospitals. The recently completed new wing almost doubled the hospital's size to its present capacity of approximately 400 beds. FABRON, of course, was used throughout.

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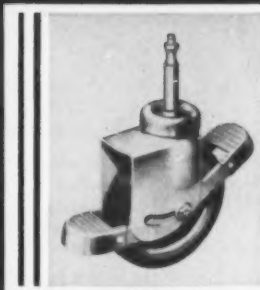
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NEWS...

Texas Hospital Group Elects Ruby Gilbert

(Continued From Page 140.)

afford the price of socialism," he asserted.

In a talk at the opening meeting of the convention, Everett W. Jones, vice president of The Modern Hospital Publishing Company, Inc., outlined a four-step program for improving hospital public relations. Mr. Jones said the public relations needs of hospitals include:

1. More friendship, religion and old-fashioned neighborliness united with science in patient care.

2. Fewer "holier than thou" actions and attitudes by doctors and hospital people.

3. More information for the general public and language that patients and public can understand.

4. Public relations programs that tell the truth instead of substituting "fancy words for honest service."

Mr. Jones also emphasized the necessity for eliminating unnecessary expansion of the Veterans Administration hospital system and integrating care of veterans in community hospital programs.

Public relations for hospitals was also discussed by Marguerite R. Johnson, feature editor of the *Houston Post*, who asked how hospitals could expect cooperation from newspapers when reporters and editors cannot get any cooperation from hospitals. Too many hospital people brush aside newspaper requests for information, she said. "The administrator is always glad to help writers get the facts for some feature story which the hospital wants published, but far too often this same administrator and his department heads seem to put every possible obstacle in the way of a reporter trying to get a news story in the emergency room," Miss Johnson said. She asked for better cooperation and understanding of newspaper needs and functions from the hospital group.

Frank Walter of Portland, Ore., president-elect of the American College of Hospital Administrators, added to the discussion of public relations by pointing out that a curious public is driving away the clouds of mystery which hospitals and doctors have traditionally thrown around their work. Mr. Walter urged administrators to take every possible step toward improving their knowledge and effectiveness. Administrators must also be willing to teach

What!

A SHORTAGE AGAIN?

WELL, figure this out for yourself: At the end of the war there were more than 100,000 short wave diathermy units in use. Under the new F.C.C. regulations starting July 1947, all of these units must be replaced by July 1952 with F.C.C. type approved models.* This averages out at 20,000 replacements a year *but the total production capacity of the industry is estimated to be only 8,000 annually.*

We manufacturers are not happy over the prospects of such an impossible demand within the next three years. It is not practical nor feasible to double or triple the production for just a short time.

The only practical solution is to try to spread the demand over the remaining three years and to draw the attention of users to these facts, so that the wise and the foresighted can anticipate *now*. To make this easier, we have a special replacement offer for hospitals with many units to trade. This special offer will make it possible for most hospitals to replace obsolete units despite budget limitations.

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*Or by costly modifications. See F.C.C. Rules and Regulations, Title 47—Part 180.

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But there's an *extra* value *no* dollar can measure . . . a value to patient therapy and administrative efficiency that is incalculable.

Call it the "human touch"—this

ability to make signal equipment designed with an eye to the small but immensely important daily conveniences and comforts of all who use it.

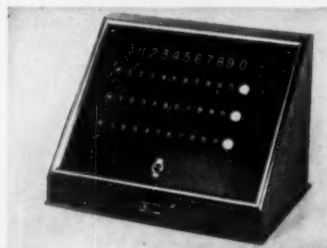
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Write for specifications bulletin on Edwards Hospital Signal Systems.



THREE-WAY VISION at no extra cost!

If the doctor can see the annunciator, he can see his paging number. It's as simple as that with this first, really modern annunciator. Flashing numerals can be seen front, left and right!

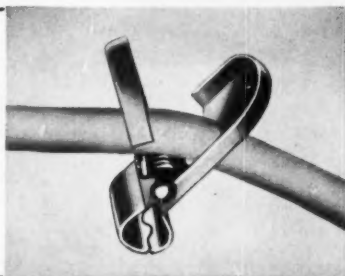


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saves patients and bedding! This Edwards ingenious, stainless steel clamp *always* keeps nurse's call button within patient's reach . . . ends "safety-pin" technique that tears bedding. Clamps on drawer of bedside table. Can be looped over bedpost, too.



Standard Faceplate . . .

also made of stainless steel, will not chip or mar. All calling stations use standard outlet plates—no costly special plates are ever needed for replacement.



Harmonious Color . . . cords, plugs, receptacles, call buttons all come in new, harmonizing soft grey finish that resists soil, blends with modern hospital decoration.

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Hospital Signal Systems

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NEWS...

others, including assistants and department heads as well as administrative residents, he concluded.

John N. Hatfield, president of the American Hospital Association, urged administrators to study the development of outpatient departments as a means of relieving the pressure for hospital beds and reducing the over-all cost of hospital care. Outpatient service is actually the practice of preventive medicine, he said. "I cannot think of a more worth-while service to render than that

of keeping people out of hospital beds or shortening their bed stay. I am convinced that every hospital should operate an integrated outpatient service," Mr. Hatfield said.

George Bugbee, A.H.A. executive director, reported on association activities and reviewed national legislation affecting hospitals. He urged support of the bill which would provide federal aid for medical and nursing education.

In addition to Mrs. Gilbert, officers named by the association were: vice

president, J. Richard Gates, Gilmer; treasurer, C. H. McCrary, Tyler; trustees, Ross O. Urban, Fort Worth, and W. U. Paul, El Paso; Sister Mary Evangeline, Port Arthur; W. H. Pigg, Austin; John G. Dudley, Houston; J. F. Morrison, San Antonio, and Julian H. Pace, Waco.

Monsignor Curry Defends N.Y. Outpatient Departments

NEW YORK.—Medical care in the outpatient departments of voluntary hospitals here is the best in the world—a fact that cannot be overlooked in any evaluation, Msgr. John J. Curry, president of the Greater New York Hospital Association, declared last month. Monsignor Curry's statement followed publication of a series of newspaper articles describing overcrowded conditions in city and voluntary hospital clinics and charging lack of courtesy and proper attention to the needs and comforts of patients and visitors.

Acknowledging that overcrowding existed and that some irritation is likely to occur in clinics which are crowded and short of personnel, Monsignor Curry said such conflicts were bound to occur and did not affect the general quality of care offered in the clinics.

He pointed out that each visit to outpatient departments of voluntary hospitals results in an average loss of \$1.65. Thirty-five per cent of more than 3,000,000 visits made in 1948 to outpatient departments of the city's voluntary hospitals were completely free, he added. The voluntary hospitals have received no outside aid toward meeting the increased cost of operating outpatient departments, Monsignor Curry explained.

Offers 21 Nursing Courses

CHICAGO. — Graduate nurses who wish to continue advance study during the summer months as preparation for special nursing fields are offered 21 courses of instruction in nursing education during the summer quarter at the University of Chicago beginning June 27, according to a university announcement. The work in nursing education is planned primarily for those interested in teaching in schools of nursing, supervision in hospitals and schools, administration of schools and hospital nursing services, public health nursing, supervision in public health nursing, and administration in public health nursing.

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TILE-TEX* . . . Asphalt Tile gives you durable, low-cost flooring, ideal for general areas such as offices, corridors, auditoriums, rooms, etc. These *quality* asphalt tiles have uniform cut and thickness, a wide range of colors and are complemented by a full line of accessories such as cove base, feature strip and borders.



*This Trio will
Floor You!*

End flooring worries on a happy note with one of the versatile Tile-TEX Trio to meet each different need.

... and **MURA-TEX*** is the smartest wall treatment you ever saw!

Companion tile to Flexachrome, MURA-TEX WALL TILE gives you a plastic-asbestos wall covering in 25 attractive colors, decorator-designed to harmonize or contrast perfectly with your Flexachrome floors.

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And remember, *every* Tile-TEX product gives you the unmatched versatility of tile-at-a-time installation. Pattern possibilities are almost unlimited. You can even de-



TUFF-TEX* . . . Greaseproof

Plastic-Asbestos Tile is especially recommended for kitchens, dining areas, machining departments and other locations where grease abuse is heavy. Here is truly *heavy duty* floor tile . . . so tough it will withstand material handling truck traffic with ease. If you're looking for a floor that combines a trim, attractive appearance with real heavy-duty durability, Tuff-TEX is the floor for you.



FLEXACHROME* . . . Plastic-

Asbestos Tile is a true aristocrat in the resilient flooring field. This long-wearing, *greaseproof* material is exceptionally strong and flexible. And what color! 33 clear, sparkling colors . . . from black to white . . . primary or pastel. Every one sharp and *true*. Choose this superb tile for your finest flooring installations.



sign special inserts, and we'll cut them at the factory to your specifications. Get the whole story on Tile-TEX Products, and how they can solve your flooring problems. For full details, write: THE TILE-TEX DIVISION, The Flintkote Company, Dept. G-1, 1234 McKinley St., Chicago Heights, Illinois.

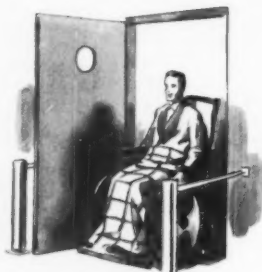
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Operated by a photo-electric "eye", Magic Doors open automatically, instantly, on approach—stay open till traffic passes through—then close quickly and silently.

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NEWS...

Williamson Outlines Program To Be Undertaken by Health Foundation

NEW YORK. — A broad outline of the program to be undertaken by the newly organized Health Information Foundation was announced by Kenneth Wil-



Kenneth Williamson

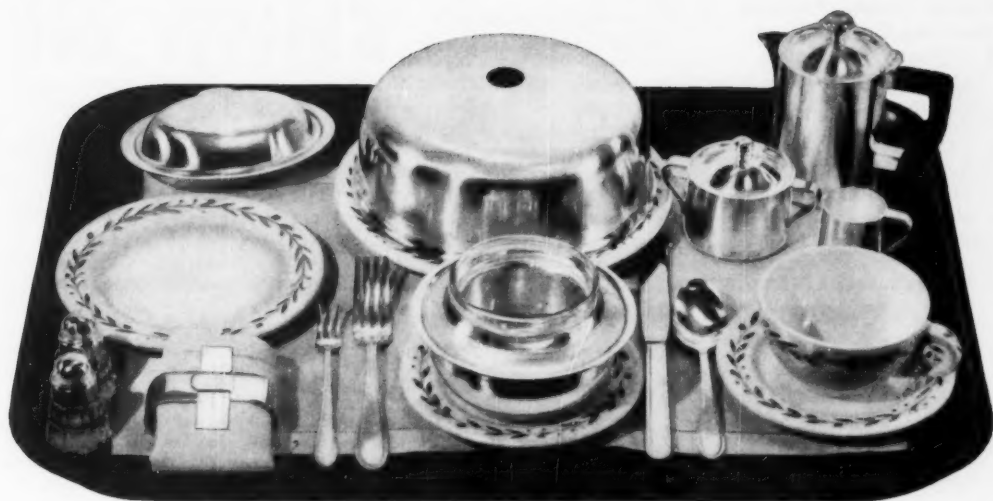
liamson, who assumed his duties as executive director of the foundation here last month. Mr. Williamson was formerly associate director of the American Hospital Association.

Among the objectives of the foundation, Mr. Williamson named stimulation of greater public interest in the progress of medical science to assure increased availability of medical services with no sacrifice of quality; cooperation with all groups concerned with medical care in determining the adequacy of existing medical facilities; adequacy of additional provision under local auspices for complete training of physicians and other health workers and for additional health facilities of all kinds, and formulation of prepayment and insurance programs in the medical field.

Mr. Williamson was a member of the staff of the A.H.A. in Chicago for six years before joining the foundation last month. He came to the association in 1943 from California, where he had been executive director of the Association of Western Hospitals and the Association of California Hospitals. Earlier, he was assistant director of Blue Cross in Southern California and administrative assistant at the Good Samaritan Hospital, Los Angeles. The Health Information Foundation was organized with the support of a number of pharmaceutical companies and others interested in medical care and allied problems. Admiral William Blandy is the foundation's president.

Four-Year Course Announced

NASHVILLE, TENN. — Vanderbilt University School of Nursing here will initiate a four-year integrated academic-professional curriculum leading to the bachelor of science in nursing degree, Julia Hereford, dean, announced last month. The course will begin next September.



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WALLACE breakfast, luncheon and dinner silverware sets *fit the tray*—an item of importance to the dietician.

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NEWS...

Admiral Boone Protests "Economy Cutback" of 18 Military Hospitals

WASHINGTON, D.C. — Appearing at a house subcommittee hearing on hospitalization problems of the armed forces here last month, R./Adm. Joel T. Boone, former White House physician and high ranking medical officer of the navy, said the defense department's "economy cutback" of 18 military hospitals was short-sighted and might ham-

per smooth functioning of medical facilities in case of war.

Admiral Boone was formerly chief of the joint plans and action division for the office of medical services in the department. Critics of the department charge that his transfer from that office without further assignment was a direct result of his criticism of the cutback program.

In the special committee hearing, Admiral Boone also said the economy pro-

gram would adversely affect the training of medical personnel for the armed services. The program involved an estimated savings of \$25,000,000 annually, according to the defense department.

Following publicity attendant on Admiral Boone's appearance at the special committee hearing, Dr. Paul R. Hawley, director of the American College of Surgeons, expressed full approval of the unification program and confidence in Dr. R. L. Meiling, director of medical services for the defense department, who was reportedly responsible for the decision to reduce military hospital operations. Dr. Hawley was medical director of the V.A. and a member of the Hoover commission's medical task force.

Approval of the cutback and unification move was also expressed by Dr. Raymond B. Allen, president of the University of Washington and former director of medical services for the defense department. "I strongly endorse the steps to achieve efficiency and economy by closing nonessential hospital facilities," Doctor Allen said.



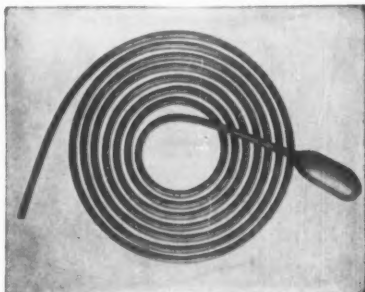
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- ✓ Safety valve technic of assembly and the use of a neoprene bag, with a low permeability to gases, eliminates the hazard accompanying distention of the bag due to the intra-intestinal pressure, particularly during long intubation.



Described by Dr. Meyer O. Cantor, Detroit; A. J. Surg., July 1946, April and June 1947, March 1948.

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Preceptor Training Course to Be Offered by A.C.H.A.

CHICAGO.—A two-day course in preceptor training will be presented here April 28 and 29 by the American College of Hospital Administrators, it was announced at college headquarters last month. The program will consist of lectures, seminars and discussion groups aimed at assisting administrators who are training graduates of the hospital administration programs, Mary A. Johnson, coordinator of graduate education for the college, said.

Subjects scheduled for lectures include qualifications of the preceptor, aids to the administrator in directing the residency, content of the residency and teaching resources. In addition, seminar groups will deal with such subjects as "How to teach" and "How to give meaning to the program." Demonstrations will be presented on right and wrong ways of presenting hospital problems to the resident, Miss Johnson said.

Taking part in the lecture and seminar program in addition to Miss Johnson and Dean Conley, director of the college, will be Dr. Malcolm T. MacEachern and Marguerite Ducker of Northwestern University, Dr. Harvey Agnew, Dr. Dwight Barnett, Dr. Frank Bradley, Ray Brown and James A. Hamilton, it was announced.

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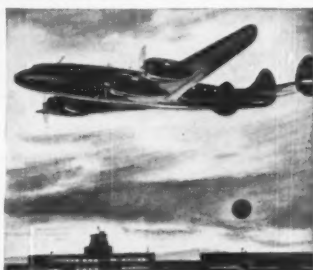
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NEWS...

COMING MEETINGS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Somerset Hotel, Boston, Oct. 22-27.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Ritz-Carlton Hotel, Atlantic City, Sept. 18-21.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Traymore Hotel, Atlantic City, Sept. 17, 18.

AMERICAN HOSPITAL ASSOCIATION, Atlantic City, Sept. 18-21.

AMERICAN MEDICAL ASSOCIATION, San Francisco, June 26-30.

AMERICAN NURSES' ASSOCIATION, NATIONAL LEAGUE OF NURSING EDUCATION, NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, San Francisco, May 8-12.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Colorado Hotel, Glenwood Springs, Colo.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs, May 30, 31.

ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION, Hotel Peabody, Memphis, Tenn., May 23-27.

ASSOCIATION OF WESTERN HOSPITALS, Olympic Hotel, Seattle, April 24-27.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Frances Marion Hotel, Charleston, S.C., May 11, 12.

CATHOLIC HOSPITAL ASSOCIATION OF AMERICA, Milwaukee Auditorium, Milwaukee, June 11-15.

IOWA HOSPITAL ASSOCIATION, Hotel Savary, Des Moines, April 21.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Lord Baltimore Hotel, Baltimore, Oct. 30, 31.

MICHIGAN HOSPITAL ASSOCIATION, Statler Hotel, Detroit, Nov. 12-14.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Memorial Auditorium and Convention Hall, Buffalo, N.Y., May 24-26.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 12-14.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Grand Rapids, Mich., May 22-24.

NATIONAL COUNCIL OF CATHOLIC NURSES, Ambassador Hotel, Los Angeles, May 4-7.

NATIONAL EXECUTIVE HOUSEKEEPERS' ASSOCIATION, Hotel Statler, Washington, D.C., June 21-24.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 30-Nov. 1.

SOUTHEASTERN HOSPITAL CONFERENCE, Vinoy Park Hotel, St. Petersburg, Fla., April 5-7.

NATIONAL TUBERCULOSIS ASSOCIATION, Hotel Statler, Washington, D.C., April 24-28.

TENNESSEE HOSPITAL ASSOCIATION, Andrew Johnson Hotel, Knoxville, June 1, 2.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 1-3.

UPPER MIDWEST HOSPITAL CONFERENCE, Nicollet Hotel, Minneapolis, May 17-19.

WASHINGTON HOSPITAL ASSOCIATION, Olympic Hotel, Seattle, April 23-27.

Action Against Excessive Fees Urged by A.M.A.

CHICAGO.—Trustees of the American Medical Association urged appropriate authorities of state medical societies to take action on the few members who charge excessive fees, it was reported here last month. Although the cases of overcharging are isolated, the trustees' statement said, "such reports create an unfavorable impression of the entire medical profession."

A number of state medical societies have established grievance committees to hear complaints of patients concerning alleged improper practice or injustices including excessive charges, the report said.

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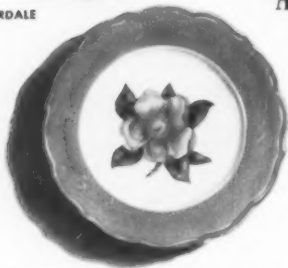
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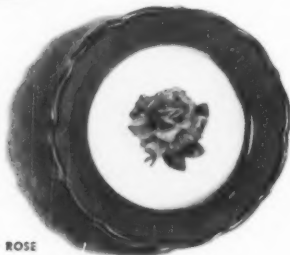
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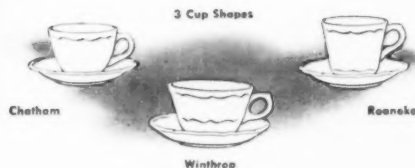
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NEWS...

Health Service, Inc., Elects Executive Officers

CHICAGO. — Health Service, Inc., organized under the laws of Illinois to supplement benefits provided by individual Blue Cross hospital service plans, held the first meeting of its board of directors here last month. The following officers were elected: president, Dr. Paul R. Hawley, Chicago; George A. Newbury, Buffalo, vice president; Abraham Oseroff, Pittsburgh, treasurer; Richard M. Jones, Chicago, secretary;

Antone G. Singen, Chicago, assistant secretary and assistant treasurer. Robert N. Rose, New York City, was named executive vice president.

Named to the executive committee were: Dr. Hawley; Thomas S. Gates Jr., Philadelphia; William S. McNary, Detroit; David T. Beals, Kansas City, Mo.; Stanley Resor, New York City.

The corporation, which will maintain its principal office in Chicago, was formed to meet the demand of firms operating in the area of more than one

Blue Cross plan for uniform benefits for employees and dependents, uniform enrollment and administrative regulations and a central agency to arrange uniformity of coverage, it was announced. It is estimated that potential enrollment among such firms approximates 10,000,000 employed persons.

Study Proposal to Form Episcopal Hospital Group

CHICAGO. — Organization of a committee to study the advisability of forming an association of Episcopal hospitals was announced here last month following a preliminary meeting of a group representing hospitals affiliated with the Episcopal Church.

Hal G. Perrin, administrator of the Bishop Clarkson Memorial Hospital, Omaha, Neb., was named chairman of the study committee. Nine hospitals were represented at the preliminary meeting, Mr. Perrin said, and others had expressed interest in the project.

"The consensus of the meeting was that there are many common problems of Episcopal hospitals," Mr. Perrin reported. Among those named were: spiritual welfare of hospital patients, cooperation among Episcopal hospitals and sponsoring dioceses, problems of social responsibility, cooperation in student nurse recruitment, and public relations involving church relationships.

"It was agreed that exchange of opinion on matters of relationship of the church and patient would be helpful," Mr. Perrin said.

"It was further agreed that there should be caution in creating another organization unless it would fulfill a definite need and not overlap functions of existing organizations."

It was suggested that if a formal organization resulted it should meet annually immediately preceding the Protestant Hospital Association meeting.




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Rixson No. 220 concealed single-acting overhead door checks—for interior, vestibule or entrance doors—are particularly desirable when small space is a factor. These sturdy, reliable units are only 2 7/8" wide x 2 1/2" high and 17" long. Checking action is controlled by two valves—for closing and latch control. When door is closed, no parts of the plate, check or arm are visible. Roller bearings throughout. Spring control easily adjustable. Hold-open feature available. Specific literature and specifications will be furnished on request.




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WASHINGTON, D. C.—L. J. Felt, 2068 14th St. N., Arlington, Va. Tel. Chesnut 6262.

Seeks Deferment of Debts

BROOKLYN, N.Y.—The Harbor Hospital here filed a petition of arrangement under the bankruptcy law last month listing assets at \$1,360,000 and liabilities of \$1,388,000, it was reported. Bernard L. Stern, hospital superintendent, asked that payment of debts be deferred for 60 days during which time the bed capacity of the hospital would be increased to provide additional revenue.

Around the Wards with Kellogg's



Patient George:

What a morning! My favorite nurse bringing me my favorite breakfast cereal! Ummmm... just like home! (Yes! And that's why hospitals serve more Kellogg's cereals than any other brand!)

Nurse Culver:

It's so easy to please patients with Kellogg's Individuals. Even my fussiest patients love Kellogg's freshness and flavor. Kellogg's are tops on the menu. Tops in flavor, too. And Individuals save me so much time!



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THE GREATEST NAME IN CEREALS
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Hubbellite Terrazzo now enables hospitals to have a floor surfacing which, properly applied, meets N.E.P.A. performance requirements for conductive floor. Hubbellite is a copper oxychloride cement, inherently conductive, not loaded with conductive particles. Being water-durable, it retains its conductive property. Use Hubbellite Terrazzo over any structurally sound, existing floor, as thin as 1/2" or as thick as necessary to build up nonlevel floors.



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Hubbellite Terrazzo can be hosed down several times a day without deterioration. In addition—Hubbellite Terrazzo has unique roach-repellent quality; inhibits on its surface the growth of many molds and bacteria; resists cooking fats and greases; is comfortable to walk on.

+ Beautiful

No conductive floor has ever looked as beautiful as Hubbellite Terrazzo . . . warm reds, rich greens, soft blue-grays and tans with countless varieties from marble chip combinations.

For further reading, write for these reprints . . .

Mailman, W. L., Michigan State College, 1941. A Bacteriologic Study of a New Sanigenic Flooring.

Farrell, M. A. and Wolff, R. T., Penn. State College, 1941. Effect of Cupric Oxychloride Cement on Microorganisms.

Researches of Mellon Institute, American Chemical Society, Vol. 19 (1941).

Hazard, Frank O., Wilmington College.

Roach Repellent Cement.

Jenkins, P. W., Sr. Fellow, Mellon Institute. A Functional Floor Surface.

Write for

HUBBELLITE TERRAZZO Catalog and Color Chart

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NEWS...

New Jersey Volunteers Use Group Dynamics

NEWARK, N.J. — An experiment in group dynamics at a conference of hospital auxiliary members was conducted successfully by the New Jersey Association of Hospital Auxiliaries here last month. With "The Future of the Voluntary Hospital" as its theme, the conference engaged in discussion of the following subjects: effect of compulsory health insurance; potentialities of voluntary insurance plans; how will the voluntary hospital pay its bills; the hospital as a health center; future of nursing education and care; the hospital and the public; the rôle of the trustee; the doctor and the hospital, and function of the auxiliary and the hospital.

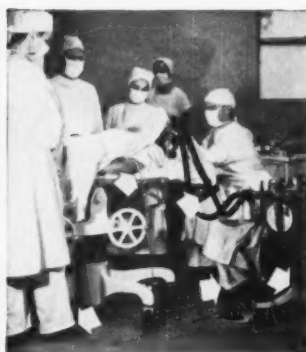
Each of the discussion groups was assigned a leader who, after 30 minutes of conference with the group, reported its conclusions. Five minutes was allowed for these presentations, and a similar period of general discussion followed.

This feature was part of a full day's session arranged for the New Jersey association by Mrs. Frank A. Lamperti, president, and Mrs. Donald R. Baldwin, vice president of the group, who also served as chairman of the conference. Appearing on the morning program as speaker was William J. Orchard, president, Orange Memorial Hospital, Orange, N.J. Raymond P. Sloan, editor, The MODERN HOSPITAL, served as moderator during the afternoon.

U. of I. Hospitals Observe 25th Anniversary

CHICAGO. — The 25th anniversary of the opening of the University of Illinois Research and Educational Hospitals was observed here April 1. Seventeen members of the hospital staff who have served continuously since April 1, 1925, were presented with keys by Dr. A. C. Ivy, vice president of the university in charge of the Chicago professional colleges. Dr. George D. Stoddard, president of the university, was guest speaker for an evening meeting. John E. Millizen, administrator of the hospitals, served as master of ceremonies.

Since the first patients were admitted in 1925, a total of 150,000 patients has been admitted for bed treatment, and 365,000 patients have received treatment in the outpatient clinics, it was reported at the meeting.



SPECIFICATION FOR SAFETY

THE ABOVE photo is one of the operating rooms of the Los Angeles Monte Sano Hospital, showing the use of the Cannon Electrostatic Grounding Intercoupler. Bead chains (noted by arrows) ground patient, table, nurses, attendants, etc. Why these precautions? Why this particular apparatus?

Type "HQ" Intercoupler with 2 typical chain assemblies. Box is bronze, insulation phenolic with 1/2 meg-ohm resistors and ground to nearest cold water pipe.



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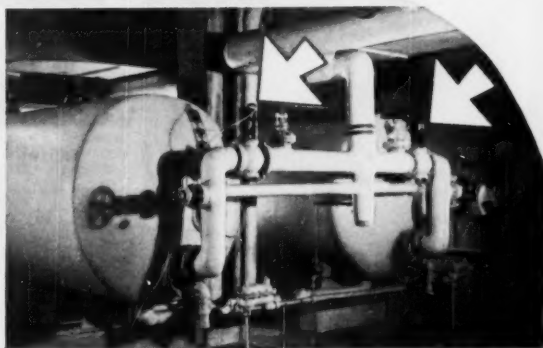
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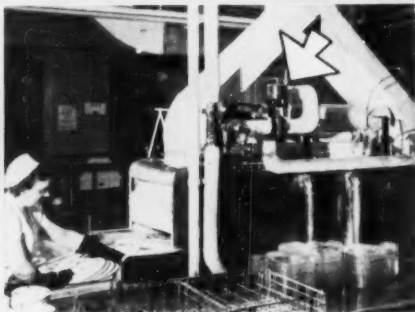
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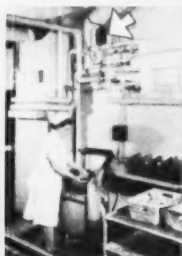
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Above: WATER HEATERS at Northwestern University



Above: STEAM TABLE—Center: DISHWASHER—Right: COFFEE URN—all at Marshall Field & Co.



COOKING KETTLE • Above: SILVERWARE WASHER
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NEWS...

Sechrist Named President of Arizona Hospital Group

PHOENIX, ARIZ.—Dr. Charles W. Sechrist, superintendent of the Flagstaff Hospital, was named president of the Arizona Hospital Association at its annual convention here last month. Doctor Sechrist succeeded Clyde W. Fox, administrator of the Tucson Medical Center. Meeting in connection with the hospital association, the Arizona Association of Medical Record Librarians voted to become a part of the state hospital group and to hold its convention annually at the time of the hospital meeting.

Discussions during the two-day convention covered payments to hospitals by Blue Cross, governmental agencies, and other outside groups; hospital nursing service; the fire safety inspection program, and the study of fire and casualty insurance rates for hospitals. "This proved to be the best convention the association has ever held from the standpoint of attendance and program," Mr. Fox reported.

Other officers named by the association were: vice president, C. H. Linville of Yuma; secretary-treasurer, G. M. Hanner of Phoenix; delegate, G. M. Hanner of Phoenix, and alternate, Lloyd French of Mesa.

Laundry Managers and Hospital Supervisors Plan Series of Meetings

NEW YORK.—A plan for regular monthly meetings to be held with supervisors of various hospital departments was developed by the Metropolitan Institutional Laundry Managers Association here last month. The first meeting, held in conjunction with hospital controllers and accountants, took up such problems as record keeping, statistical reports, linen cost analysis, and other specific operations involving both laundry and accounting interests.

Announcing the forthcoming series of meetings with other departments, Andrew Mezei, vice president of the association, said the purpose was to develop closer cooperation between laundry manager and the supervisors of other hospital departments, to create a clearer understanding of the interrelationship among hospital departments and thus to develop more efficient laundry operations.

6

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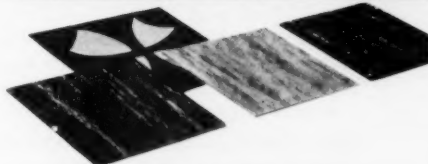
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NEWS...

Brazil Will Be Host to Third International Institute on Hospital Administration

WASHINGTON, D.C.—The Third International Institute on Organization and Administration of Hospitals will be held in Rio de Janeiro in June 1950, it was announced here last month. Leading educators in hospital work from nine countries will lecture on systems and methods of hospital operation.

Twelve institutions interested in the development of hospital service have

joined 19 official agencies of the Brazilian Government in the organization of this meeting, which will be held in the Ministry of Education of Rio beginning June 18 and closing July 1.

Officers of the Pan American Sanitary Bureau—regional office of the World Health Organization—the Inter-American Hospital Association, the Ministry of Education and Health, and the National University of Brazil have officially announced the meeting, which is open to all countries.

Lectures will be given simultaneously in Portuguese, Spanish and English, it was explained. Attendance at the institute has been limited to 200 students, the report said.

Massachusetts Association Elects New Officers

BOSTON.—Dr. Warren F. Cook, executive director of New England Deaconess Hospital here, was elected president of the Massachusetts Hospital Association at its recent meeting. Dr. Gerald F. Houser, director of the Faulkner Hospital, was named secretary and Georgie M. Boulter of New England Baptist Hospital was elected treasurer.

The featured discussion of the program was a panel on "hospitals and the practice of medicine." Dr. L. S. McKittick, president-elect of the Massachusetts Medical Society, represented the point of view of the physician and John Hayes, director of Lenox Hill Hospital, New York, and past president of the American Hospital Association, discussed the question from the point of view of the hospital. Other discussants represented the separate views of the pathologist, radiologist, anesthesiologist, administrator and hospital trustee.

Dr. Albert G. Engelbach of Cambridge and Albert O. Davidsen of Attleboro were named association delegates to the A.H.A. William S. Brines of Malden and Dr. W. B. Osgood of Worcester were elected alternates.

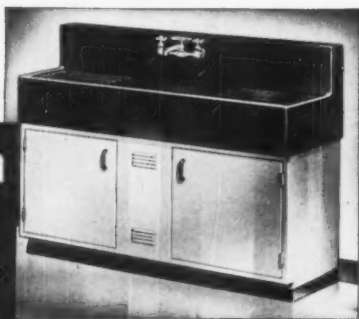
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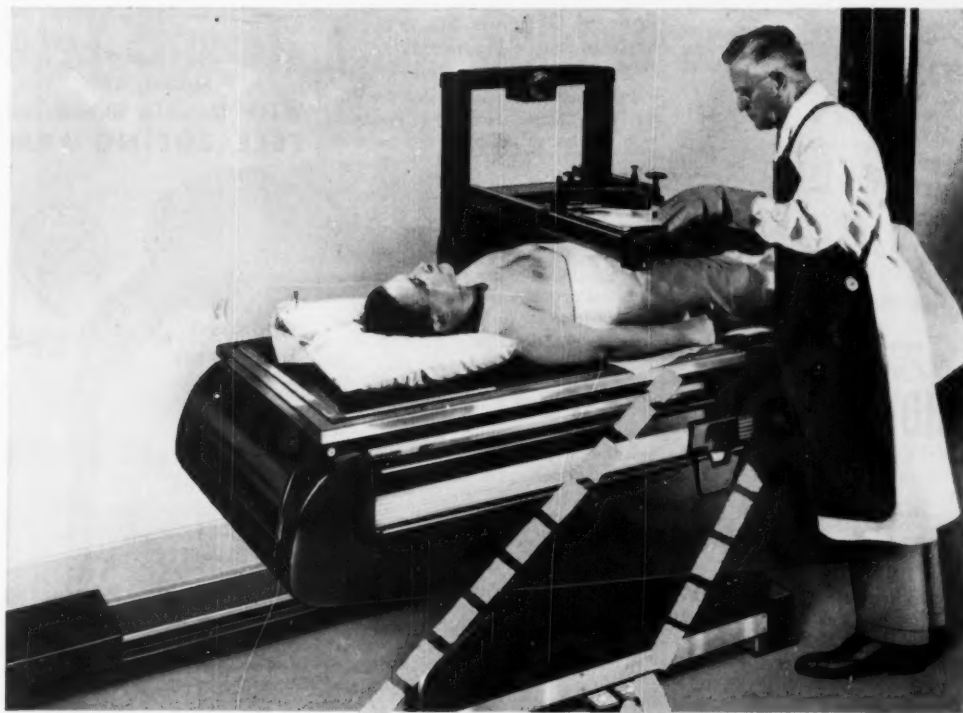
C. G. Campbell, President

3033 SOUTH CENTER STREET • ADRIAN, MICHIGAN

Establishes Scholarship Fund for Hospital Housekeepers

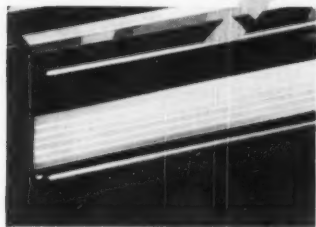
CHICAGO. — Establishment of the Pacific Mills Hospital Education Fund for training hospital housekeepers was announced last month by the American Hospital Association. The fund will provide 10 scholarships for the course in hospital housekeeping established by the association at Michigan State College, the announcement said.

The eight-week course starts April 3 and is taught by members of the college faculty, association staff specialists and other trained experts, it was explained. The curriculum covers budget and record keeping, personnel management, job analysis, supplies and equipment, linens, furnishings, bacteriology, fire prevention and employee training methods. Field trips, laboratory work and assigned reading supplement classroom lectures.

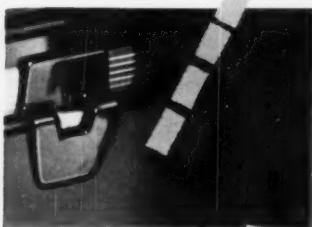


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Federal Officials Study Valley Forge Hospital

WASHINGTON, D.C.—Federal medical and hospital officials visited the Valley Forge General Hospital at Phoenixville, Pa., last month to study a hospital management research project being conducted there by the army medical department.

The Valley Forge project has been in operation for six months and has developed several improvements in hospital and management procedures which are scheduled for early adoption at other army general hospitals.

Among the improvements that have been under study at Valley Forge are the use of business machines in many new phases of hospital administration and the development of a new organizational structure for general hospitals, it was reported.

"The general application of new procedures developed at Valley Forge is expected to constitute a major contribution to the more economical and efficient operation of the army hospital system," the department of defense said.

Celebrates 30th Anniversary

CHICAGO.—The 30th anniversary of the Mount Sinai Hospital was celebrated with an open house at the hospital here last month. One entire floor was given over to medical exhibits for the day. Dr. Stephen Manheimer, hospital director, reported. Guests visiting the hospital talked to doctors, medical social workers, nutritionists and others on the hospital staff and watched demonstrations covering various phases of the hospital's work, the report said.

The hospital has grown in its 30 years from a 60 bed institution to the present 340 bed medical center associated with the Jewish Federation. Dr. Manheimer stated.

Fund Drive Breaks Record

NEW YORK.—More than \$2,600,000 has been collected and pledged to the 1950 United Hospital Fund Drive, Roy Larsen, fund president, announced here recently. This is \$40,000 in excess of the total raised in last year's campaign, the announcement said.

The fund has received 15,000 more contributions than in 1949, Mr. Larsen added, indicating that this was the largest number received in the history of the fund's campaigns.

HOSPO-LITE MODEL BT With Double Extension TELESCOPING ARM



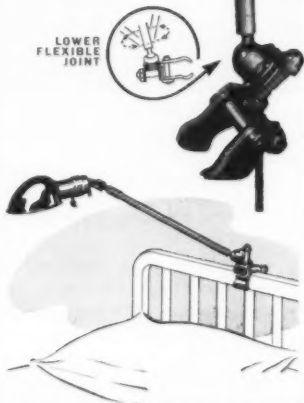
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Model BT extends to swing (3 arm lengths available) in 16", 24" and 32" circle from clamp. Cordage is held along extension arm, with clips.

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HOSPO ORGANIZATION
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WHY Hospitals and Schools are turning to

MELMAC* TABLEWARE

QUESTION:

IS MELMAC tableware made of one of the hardest synthetics known?

ANSWER:

Yes... it is made from a thermosetting plastic material (melamine-formaldehyde) combined with very small particles of filler and coloring agents. It is molded and permanently set under high temperature and pressure.

Q: Is its color lasting?

A: Yes... the color, incorporated in the basic compound, runs throughout the molded piece. MELMAC's color and lustre remain for the lifetime of the tableware.

Q: IS MELMAC tableware odorless?

A: Yes... and tasteless, too.

Q: Will it soften on exposure to heat?

A: No... nor will it catch fire. MELMAC Plastic has the ability to withstand hot water. Furthermore, common solvents (alcohol, acetone, carbon tetrachloride) do not harm it.

Q: How about breakage?

A: Resistance to breakage is one of the greatest advantages offered by MELMAC tableware. On this score alone, MELMAC tableware saves many dollars, improves personnel relations and reduces reserve inventories.

Q: What are its other advantages?

A: There are *many* more big sales points for MELMAC tableware. Its weight, for example, is approximately only one-third that of similar earthenware or china parts. It is easier to carry, easier to stack. It is quieter to use—reduces clatter and noise—helps produce a more pleasant, relaxing atmosphere. Its excellent insulating properties tend to keep cold food cold and hot food hot.

Q: Does MELMAC tableware require any special care?

A: MELMAC heavy duty tableware is new and somewhat different from china or earthenware. Be sure that your customer uses adequate detergents in his dish-

washer and maintains washing conditions in accordance with leading health authorities' suggestions... namely, wash at 140°-160° F. and rinse at 180° F.

If cups discolor from coffee as they frequently do with china, wash them by hand using a detergent containing a wetting agent. If this is not practical, immerse in a 5% solution of Clorox and water together with a small amount of detergent containing a wetting agent to remove discoloration. Your customer has been doing this with china, and will be familiar with the technique.

And, although MELMAC tableware can be washed in the same equipment as earthenware or china, it does not stand boiling indefinitely. It is not recommended for use where parts are boiled after each service.

MELMAC will not catch on fire or melt; however, do not place in oven or over flame.

Q: Where is MELMAC tableware being used?

A: It is being used with great satisfaction in restaurants, schools, colleges, clubs, hospitals and other institutions throughout the country.

Q: Is MELMAC tableware saving money for hospitals, schools, colleges and other institutions?

A: Yes! Actual records kept by restaurants, hospitals, schools and other institutions show that MELMAC tableware is providing *tremendous savings* by its phenomenal resistance to breakage alone!

If you would like any further information, write Plastics Department, American Cyanamid Company, 30-40 Rockefeller Plaza, New York 20, N. Y.

*MELMAC is American Cyanamid Company's registered U. S. trade mark for condensation products of aldehydes and amines.



NEWS...

Vassar Hospital Affiliates With N.Y.U.-Bellevue Regional Hospital Plan

NEW YORK.—Affiliation of Vassar Brothers Hospital, Poughkeepsie, N.Y., and the New York University-Bellevue Medical Center under the medical center's regional hospital plan was announced here recently. The regional plan provides expanded training opportunities for the medical staffs of hospitals located outside the metropolitan area as well as for practicing physicians

in the communities served by these hospitals, it was explained.

Under the new affiliation, one or more members of the Vassar Brothers Hospital intern staff will be given the opportunity to take a full year's resident training at the center, while others will be eligible to take shorter, part-time courses. Under the regional plan these physicians are obligated to return to their hospital for at least one year following completion of the course.

In addition, the announcement said,

medical center faculty members will travel to the Vassar Brothers Hospital, as they do to all its affiliated hospitals, to participate in clinical conferences or conduct seminars, ward rounds and other forms of teaching services.

Under the agreements made with the regional hospital plan, the participating hospitals undertake to carry out a comprehensive educational program for their medical staffs. Vassar Brothers Hospital already has a teaching program of this nature but through participation in the plan expects to strengthen its present program, it was stated. As is done by other hospitals in the plan, Vassar Brothers will appoint a coordinator who will take the responsibility for the functioning of its training program. He will also be eligible to take part in staff conferences at the medical center and study at the center's postgraduate medical school.



How

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WASTE

RECEPTACLES

● Everybody is automatically a member of your cleaning department by conveniently placing Bennett Bilt Waste Receptacles to invite their use. These waste receptacles are sanitary, economical and a major help to cleanliness and neatness. Put them to work for you today.

ONLY  WASTE RECEPTACLES HAVE ALL THESE FEATURES

- Non-rusting stainless steel feet eliminate rusting and rust marks
- Made of extra heavy-gauge Mayari R, Bethlehem's corrosion resistant steel
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- Reinforced corners
- Strong springs keep doors closed providing greater sanitation and eliminating fire hazards
- Rounded corners for structural strength and pleasing appearance
- Baked enamel finish... white or green

These are a few of the many features that make Bennett Bilt Waste Receptacles a natural "buy." Quality and every consideration for hard usage are self-evident both inside and outside of these receptacles.

Write for fully-illustrated catalog TODAY.



Independently hinged doors



High tension springs keep doors closed



Burlap bags or galvanized liners are quickly removed

THE BENNETT MANUFACTURING CO., ALDEN, N. Y.

CUSTOM METAL CRAFTSMEN SINCE 1906

Army Sponsors Inter-Agency Hospital Institute

WASHINGTON, D.C.—The third Inter-Agency Hospital Institute sponsored by the army will be held April 17 to May 5 at the Army Medical Center here, the Surgeon General's office has announced. The purpose of the institute is to give hospital managers of federal agencies controlling hospitals a wide concept of management of federal and civil hospitals so as to create an objective attitude of leadership in hospital management and administration, it was explained. Participating agencies are the army, navy, air force, Veterans Administration, Public Health Service and Indian Affairs Bureau.

Col. Floyd L. Wergeland, M.C., and Col. B. L. Steger, M.C., of the education and training division, Office of the Army Surgeon General, will be monitors for the next institute, the announcement said. It is anticipated that about 33 representatives will attend.

N.J. Plan Raises Rates

NEWARK, N.J.—The Hospital Service Plan of New Jersey has increased subscription rates because of increased hospital costs, J. Albert Durgom, executive director of the plan, announced here recently. Group rates were raised from \$1 to \$1.20 a month for single subscribers and from \$2.60 to \$3.56 a month for families, it was explained.

Linen Service Keeps Pace with Expansion . . .

at the Illinois Masonic Hospital, Chicago, Ill.



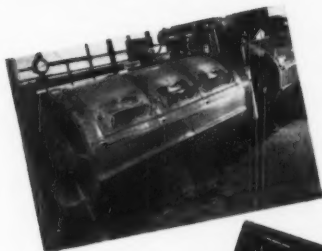
HOFFMAN
Laundry
Equipment

Another case where

delivers better production with modern economy

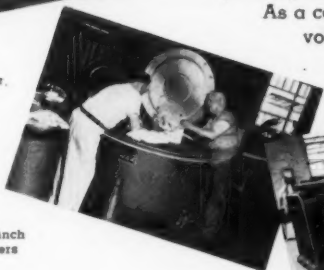
An expansion program covering several years could, one day, bring a breakdown in linen service. The 240-bed Illinois Masonic Hospital avoided this eventuality by planning an enlarged laundry plant at the outset—and following the recommendations of Hoffman Laundry Engineers for new equipment in advance of their need.

As a consequence, linen service has been maintained, greater volumes of linen processed and normal work-week observed throughout the expansion to date



New 42 x 84
"Silver Crest" washer,
for larger loads

48" open-top
Extractor keeps
pace with ex-
panded volume



Far right) 6-roll, 120-inch
Hoffman Ironer delivers
flatwork on time



**Write for your
FREE Survey**

Analyzes your laundry operating costs, surveys your linen requirements and suggests control schedules; furnishes new layout plans, recommends equipment to help you save floor space, time, labor, fuel, supplies and linen. Write for it.

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COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION

NEWS...

Greater New York Fund Issues Report on Health, Welfare Needs of City

NEW YORK.—A study of the health and welfare needs of New York City has been released here by the Greater New York Fund to aid the fund in the equitable distribution of the philanthropic dollars it collects. The study showed that Manhattan far outstrips the other boroughs in its need for health and welfare services. Brooklyn, which has the highest population numerically

of any borough, ranks next in extent of need. Following in order are the Bronx, Queens and Richmond, it was disclosed.

According to the study, Manhattan has the greatest number of overcrowded dwellings, the greatest need of major repairs and plumbing, the highest proportion of persons needing public assistance, the highest death rate and the highest annual infant and maternal mortality rates. Also, it has the highest incidence of tuberculosis, the largest number of delinquent children and a

high record of truancy investigations.

In a foreword to the study, Frederick W. Gehle, executive director of the Greater New York Fund, pointed out that it was designed primarily to guide the fund in determining whether the welfare organizations serving New York are meeting existing problems, and whether the fund's plans of distribution are working as effectively and equitably as possible. Mr. Gehle said that "in the process of making the study, primarily concerned with the analysis of fund grants, it became necessary to develop a number of indices or measures of general needs for welfare and health services. This material forms a background against which the day-to-day needs of our city and those who live here may be seen in clearer perspective."

New York City Hospitals Need Additional Funds to Carry Out Program

NEW YORK.—The \$150,000,000 hospital bond issue authorized last November for expansion and rehabilitation of the city hospital system will not be sufficient to meet anticipated needs, Dr. Marcus D. Kogel, commissioner of hospitals, reported last month. An estimated additional \$10,000,000 a year will be needed to put the department's five-year program into effect, Dr. Kogel told Mayor O'Dwyer, following a study made by a special committee on needs of the department of hospitals. The committee estimated that two new hospitals would be needed, recommended three additions to existing hospitals and replacement of seven existing facilities. The entire program would include 2250 new beds and would replace 7350 beds now housed in obsolete structures, it was reported. The committee's program would bring the department's facilities in line with trends toward an increase in the average age of the population, toward specialization in medical care, group practice and medical insurance, it was explained.

Practical Nurses to Meet

NEW YORK.—The ninth annual conference of the National Association for Practical Nurse Education will be held at Grand Rapids, Mich., May 22 to 24, Hilda M. Torrop, executive secretary of the association, announced here last month.

Surgically Clean...in 3 minutes

with SEPTISOL
Antiseptic Liquid Soap
Containing HEXACHLOROPHENE

SEPTISOL enables the surgeon to secure bacteriologically cleaner hands in less than $\frac{1}{3}$ the time required by conventional scrubbing methods. He, and members of the operating team, can eliminate irritating brush-scrubbing and antiseptic after-rinses from their scrub routine because such procedures are not necessary with SEPTISOL.

The elimination of brushes and rinses saves the hands from needless abuse. In addition, SEPTISOL contains a vegetable emollient that leaves the hands soft and clean. This emollient and the low pH of SEPTISOL prevents keratolytic action and "soap irritation".

Over 10 million scrubs in hundreds of hospitals have proven SEPTISOL non-irritating to the normal skin.

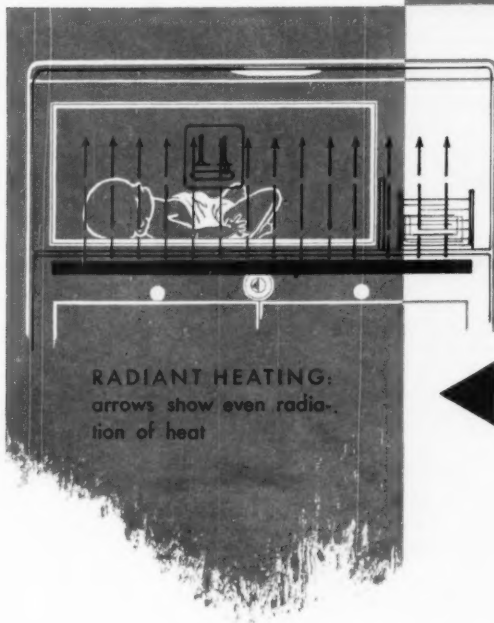
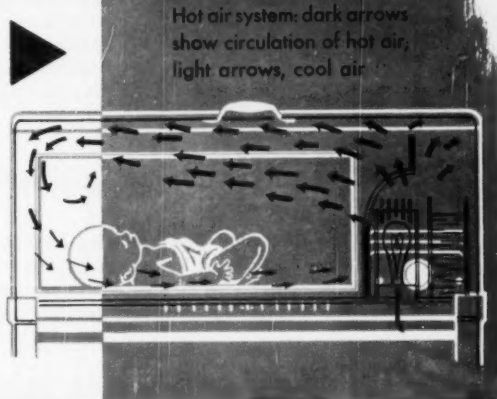
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Most infant incubators use hot air for heating. In these systems the heated air travels by gravity alone; hot near the heating elements, steadily losing heat as it circulates across the top to the opposite end, where it cools, sinks and returns across the bottom to the elements. The hot air continually rises to the top, requiring the overheating of the upper surface to obtain a minimum of warmth on the floor of the compartment. It is impossible to adequately control the temperature at all points within the incubator.



Only the LIVSEY Infant Incubator uses RADIANT HEATING. Air is not used as a heating medium, but instead, heat waves are radiated from the entire bottom and back surfaces of the infant compartment, offering steady, continuous warmth. There are no drafts or cold areas. The temperature is easily adjusted by means of a single control.

The LIVSEY Infant Incubator is especially designed for one purpose: to protect the infant's life. It is precision made of the finest materials; constructed for administration of aerosol therapy and oxygen, as well as other advantages, conveniences and protective safeguards. For a free, illustrated brochure, write to the LIVSEY Equipment Company, Dept. 11, 18938 Winslow Road, Cleveland 22, Ohio.

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★ INDEPENDENCE

★ COMFORT



Hospital personnel as well as patients enjoy the self-adjusting features of The Campbell Bed. The fact that the patient has a finger-tip control of his comfort at all times eliminates any need for assistance when changing bed position . . .

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HOSPITAL BUILDING
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- LESS CONCRETE FORM WORK . . . reduces lumber costs and form building time.
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NOTE: Cantilever design at stair case opening.

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NEWS...

Mayo Clinic to Start 10 Story Building

ROCHESTER, MINN.—Construction of a new 10 story building at the Mayo Clinic here will be undertaken next summer, H. J. Harwick, chairman of the board of members of the Mayo Association, and Dr. A. R. Barnes, clinic chairman, announced recently. The new unit will cost approximately \$12,000,000, it is estimated.

Explaining the board's decision to go forward with the construction project, Mr. Harwick said the move was made after several years of concentrated study by the building committee and the clinic architects, Ellerbe and Company of St. Paul. "With the uncertainties ahead in medicine and the uncertainties ahead in the general economy, this decision has not been an easy one," Mr. Harwick declared, "however, no institution can stand still. It must go ahead or go back.

"Capital invested in plant, with due regard for the essential balance between research, education and clinical practice, is essentially an investment in the present and future staffs, and particularly their professional resources brought to focus in the medical and surgical care of human beings afflicted with disease. Under any and all conditions which may be ahead of us, it is an investment more adequately safeguarding the future of the clinic than are securities or money in the bank.

"As Dr. Mayo so aptly put it in the discussion preceding the decision: 'This is fundamentally an investment in ourselves.'"

18 Military Hospitals to Be Closed or Transferred

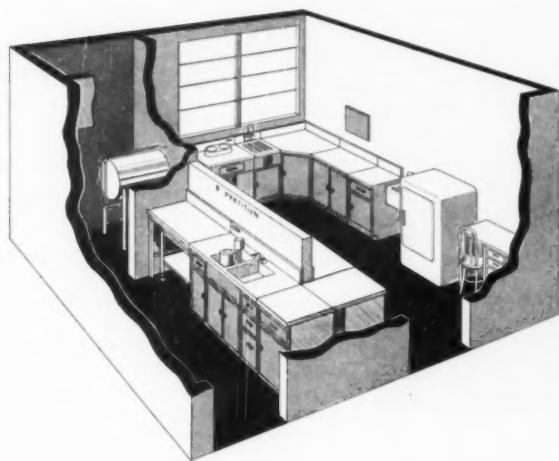
WASHINGTON, D.C.—Eighteen military hospitals in the United States were ordered closed or transferred by Secretary of Defense Louis Johnson in a unification move that is estimated to save \$25,000,000 a year in the operation of the armed forces medical services.

The order is to be carried out over a period of five months and will not interfere with federal care of patients, the announcement said. Some hospitals to be closed will be used for Veterans Administration patients, it was explained.

The secretary has authorized Dr. Richard L. Meiling, director of defense medical services, to discuss V.A. hospitalization in military hospitals with officials of the V.A. and budget bureau.

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1. 85L-24D—Drawer-Cupboard Unit without Splashback
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18. 85ES-2—Electrical Duplex Plug Strip

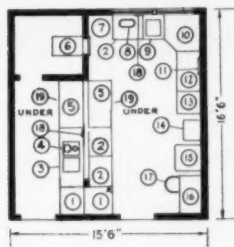
GROUP 2 (NOT FIXED)

4. Olson Bottle Washer
7. 85P6398AL—Waste Receptacle—Silver lustre Finish
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15. Refrigerator
16. 85P6238—Nurses' Desk—Silver lustre Finish
17. 85P6327AL—Chair—Silver lustre Finish
19. 85P6356—Milk Cart

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hospital furniture
in the world**

With Moduline you can provide furniture for your milk formula room, nurses' stations and laboratory rooms, that will meet your needs for years to come. Moduline, by Aloe, is styled for tomorrow. It comes in architecturally approved widths and depths so that custom-built facilities may be developed from standard Moduline units. Here are some characteristic details: concealed hinges, baked steel finishes with stainless steel table tops. Utilities can be top or splashback mounted. Write for special booklet T-300 and learn how Moduline can meet your furniture needs.

*Special Schematic Layouts for
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NEWS...

Urges General Hospitals to Help Solve Problems of Tuberculosis Care

CHICAGO.—Tuberculosis is not dangerously communicable when proper technics are used, and general hospitals should, therefore, accept tuberculous patients and help solve the problem of overcrowding in tuberculosis hospitals especially in large cities, Dr. O. L. Bettag, medical officer of the Municipal Tuberculosis Sanitarium here, said in a

talk at the annual meeting of the Chicago Hospital Council last month. Doctor Bettag also urged voluntary hospitals to take part in the tuberculosis case-finding program by inaugurating routine chest examinations for all patients. Mrs. Edna Nelson, administrator of the Women's and Children's Hospital, described the chest survey system in effect there.

Ray Brown, superintendent of the University of Chicago clinics, reported that all clinic patients have microfilm

chest examinations at a cost of 16 cents a film. The survey had revealed active tuberculosis in 2 per cent of all cases and many other chest abnormalities, Mr. Brown said.

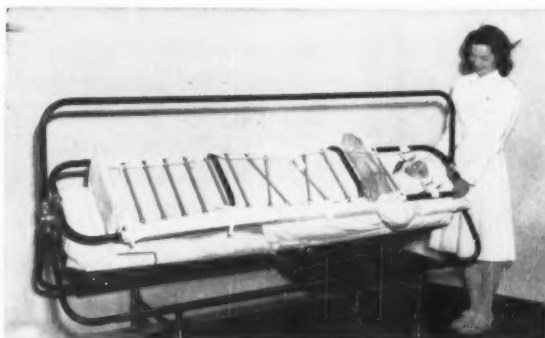
Leo Lyons, administrator of St. Luke's Hospital, was named president of the association succeeding Msgr. John W. Barrett, director of Catholic hospitals for the Chicago archdiocese. Other officers elected were: vice president, Charles Hassenauer, Garfield Park Hospital, and secretary-treasurer, Leslie Reid, Presbyterian Hospital.

Mr. Lyons reported that meetings with representatives of the Chicago Welfare Administration and the Illinois Public Aid Commission had been held looking toward increases in the rates paid to hospitals by these agencies for care of indigent patients. Mr. Lyons said that representatives of the welfare agencies were sympathetic but poor. A committee of the Chicago Hospital Council and the Illinois Hospital Association is preparing information to present to the agencies, he said.



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A new development in the treatment of immobilized patients, the Stryker Turning Frame is essential equipment for the modern hospital. While held gently but firmly between the two frames of this unique device, any patient can be quickly turned by one nurse. One frame is removed after turning, and the other, covered with taut canvas and pad, provides a smooth, comfortable resting surface. Lying on the anterior frame, the patient can read, write and feed himself with ease. In cases of pelvic, intertrochanteric or cervical fractures, either end of the frame can be elevated to provide continuous traction throughout the turning process. Built of the finest materials, and widely accepted by orthopedists, gynecologists and neurosurgeons, the Stryker frame saves valuable nursing time and increases the comfort and well-being of the patient.

*** You are invited to write for complete information. Dept. H.**

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MICHIGAN**

Launch Joint Fund Drive

TERRE HAUTE, IND.—A joint fund-raising campaign for the Union and St. Anthony's hospitals was announced last month by Leonard B. Marshall, president of the Union Hospital board and Anton Hulman Jr., chairman of the advisory board of St. Anthony's Hospital. The two institutions have joined forces in an appeal for funds with which to expand their facilities, the announcement said. Contemplated are a new wing and structural remodeling of the old wing at St. Anthony's Hospital and a new structure linking two existing buildings at the Union Hospital. Dr. Herman Smith of Chicago has been consultant in the development of the joint program, the announcement said.

Multiple Sclerosis Clinic

NEW YORK.—A research clinic to investigate multiple sclerosis and related disorders was opened officially at Bellevue Hospital here last month. The new clinic was made possible by a grant of more than \$100,000 from the National Multiple Sclerosis Society to New York University postgraduate medical school, a unit of the New York University-Bellevue Medical Center, it was announced. The clinic will be staffed by members of the school's faculty.

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and well-being of your patients and efficiency of your staff**

MORE and more executives who operate hospitals and sanatoriums are becoming aware of the physical and psychological benefits to patients and staff as the result of the proper use of color.

● **That accounts** for the tremendous interest in Pittsburgh COLOR DYNAMICS for the hospital field.

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● For a complete explanation of COLOR DYNAMICS and how to use it, send for our **FREE**, profusely illustrated booklet which contains numerous examples of its use.

Better still, we'll gladly make a scientific color engineering study of your hospital, without cost or obligation to you. We have trained color experts at each of our 75 warehouses. Call your nearest Pittsburgh Plate Glass Company branch and we'll gladly send one of these representatives to see you at your convenience. Or mail this coupon.

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Long noted for simplicity and highly automatic action, Keleket Multicron Controls are now even simpler and more automatic than before.

The new 300 MA Multicron Vertical Control automatically assumes greater responsibility. In addition, it provides increased facilities for consistently high quality diagnostic radiographs. This reduces possibilities for error and the cost of film "retakes."

The new Multicron safeguards you as your changing radiographic technics require greater power capacities. It is never necessary to trade in this new Multicron for a higher powered unit.

INCREASING CAPACITY REQUIRES ONLY TIMER EXCHANGE

Simply exchange timers to meet increasing requirements. And you retain the same transformer and control because it is capable of producing 500 MA at 125 KV.

**Increasing capacity
to 500 MA requires
only timer exchange**



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**More proof—that this outstanding
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Swift—Sure! Attacks vegetative pathogenic bacteria and fungi. Never fades or discolors floors, walls, bedding furniture.

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Potent — Effective! Completely safe and sure for the disinfection of dishes and utensils used by patients with contagious diseases.

More Economical! Gallon price reduced from \$3.00 to \$2.70! Diluted 100 times, O-syl makes a potent disinfectant solution for general use—for as little as 2.2¢ per gallon!

Highly concentrated! Even when greatly diluted, O-syl is extremely powerful in its anti-bacterial action.



Non-corrosive! O-syl guards expensive instruments from rust, safely and surely disinfects rubber goods.

Non-Specific! Eliminates the necessity of keeping several germicides for various specific purposes.



FOR SAFETY'S SAKE... the significant new development in disinfectants

**10% PRICE REDUCTION!
SAME DISCOUNTS!**

O-SYL (HOSPITAL STRENGTH, PHENOL COEFFICIENT 5) IS LISTED AT \$2.70 PER GALLON (FORMERLY \$3.00) IN GLASS CONTAINERS.

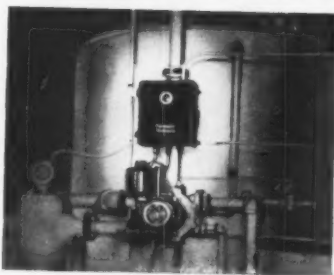
5% discount for shipment in individual 5-gal. drums. 10% discount for shipment in individual 10-gal. drums. 20% discount for shipment in individual 50-gal. drums. Freight prepaid on 10 or more gallons shipped at one time to one address. Terms 2% 10 days, 30 days net.

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With Permutit's modern design and fully automatic operation, you are assured of zero hard water *all* the time. Water is completely softened from the beginning of the run to the end. You can be certain of perfect washes with the minimum of soap or detergent.

Older softeners sometimes fail to yield completely softened water, which impairs the quality of the wash and requires extra consumption of soap.

MODERNIZE your old softener!

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Write for full information to The Permutit Company, Dept. MH-4, 330 West 42nd Street, New York 18, N. Y., or to Permutit Company of Canada, Ltd., Montreal.

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Water Conditioning Headquarters for over 36 years

ABOUT PEOPLE

(Continued From Page 88.)

burg State Research Hospital, Galesburg, Ill. **Dr. Walter Baer**, formerly superintendent of Manteno State Hospital, has succeeded Dr. Graff at the Peoria hospital.

Dr. Louis Belinson, who served as superintendent of Dixon State Hospital following the death of **Dr. Warren G. Murray**, has been appointed superintendent of Jacksonville State Hospital, Jacksonville, Ill., to succeed **Dr. James L. Smith**, who resigned. **Dr. C. K. Bush** is serving as acting superintendent at the state hospital in Dixon, Ill.

Robert D. Southwick assumed the duties of administrator of Concord Hospital, Concord, N.H., on March 1, succeeding Conant Faxon. Mr. Southwick went to his new post from Gallinger Municipal Hospital, Washington, D.C., where he was assistant administrator.

Rayner J. Kline is the administrator of the Burdette Tomlin Memorial Hospital now under construction at Cape May Court House, N.J. Mr. Kline, former assistant executive director of Jewish Hospital, Cincinnati, began his new duties on March 1. When completed, the new hospital, which is estimated to cost about \$725,000, will have a capacity of 65 beds.

Department Heads

Donald J. Parsons has been named director of the new personnel department of Evanston Hospital, Evanston, Ill. For the last three years he has been executive and training services manager for Aldens, Inc., a mail order and retail store chain. He was staff assistant to the administrator of the University of Iowa Hospitals from 1939 to 1943, and from 1943 to 1946 was a wage analyst, economist and, finally, disputes hearing officer with the War Labor Board in Chicago.

Charles Bonner is chief of the information service at Memorial Hospital Center for Cancer and Allied Diseases, New York City, which has taken over the duties of the former public relations department of the center. **Mrs. E. H. Davison** is assistant chief of the service.

Dr. Jacob M. Wisan, former director of the Joseph Samuels Dental Clinic in Providence, R.I., became chief of the dental service at the new Veterans Administration Hospital, Brooklyn, N.Y., on March 1.

The MODERN HOSPITAL

don't wait get the facts about this money-saving accounting system now!

Build your hospital accounting system around the National Window-Posting Machine. You'll get markedly improved service that your patients will like at much lower cost than any



hand accounting system can render.

The National System handles with equal facility the all-inclusive rate or the specific service rate. In a *single* operation it posts the patient's bill, the account card and the journal, and prints the amount of the posting on the charge voucher. All bills are instantly available, since all items are posted daily and are always in balance.

Ask your local National representative for a demonstration of the savings a National Window Posting Machine can make for you... savings which often repay its entire cost within a year! Or, write to the Company at Dayton 9, Ohio.



THE NATIONAL CASH REGISTER COMPANY

Dr. Stanley W. Olson, assistant director of the Mayo Foundation, Rochester, Minn., has been appointed dean of the University of Illinois College of Medicine and medical director of the university's Research and Educational Hospitals. He succeeds **Dr. John B. Youmans**, who has accepted the deanship of medicine at Vanderbilt University, Nashville, Tenn.

Cora Pike has been appointed director of nursing, Woman's Hospital, New York City. Following service in the army nurse corps, where she attained the rank of major, Miss Pike served as

superintendent of Gardiner General Hospital, Gardiner, Me., and more recently has completed requirements for an M.A. degree in nursing education, with a major in administration of a nursing service, Teachers College, Columbia University.

Stella Heinze, formerly executive housekeeper of North Carolina Baptist Hospital Association, Winston-Salem, N.C., has resigned to accept a similar position at George Washington University Hospital, Washington, D.C. There she succeeds **Mrs. Hertha McCully** who recently became executive housekeeper of the Orrington Hotel, Evanston, Ill.

Trustees

Laurance S. Rockefeller has been elected president of the board of managers of Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City. Mr. Rockefeller, who is the grandson of the late John D. Rockefeller, succeeds **Reginald C. Coombe**, who was elected chairman of the board after 10 years of service to the hospital.

Miscellaneous

Brother Christopher Lynch, C.F.A., R.N., B.A., assistant general and secretary of the Congregation of Alexian Brothers, received the Cross Pro Ecclesia et Pontifice at a ceremony which took place in the chapel of Alexian Brothers Hospital, Chicago, on March 19.

Dean Conley, executive secretary, American College of Hospital Administrators, has been awarded an honorary membership by Alpha Delta Mu, professional fraternity in hospital administration at Northwestern University. The honor was conferred upon Mr. Conley in recognition of his outstanding contributions to the profession of hospital administration and to the students in the program at Northwestern University.

Theodore W. Fabisak has resigned as executive secretary of the Massachusetts Hospital Association to return to the State Department of Public Health. He had been on a leave of absence from the department while serving the association for a year.

Stuart W. Knox has been engaged by the Massachusetts Hospital Association as a full-time accounting specialist. He will work from M.H.A. headquarters under the sponsorship of the Council on Administrative Practice.

Joseph P. Richardson has been admitted to partnership in the firm of Coolidge, Shepley, Bulfinch and Abbott, architects, Boston.

Deaths

Bert F. Arrington, administrator of Balboa Hospital, San Diego, Calif., and a past president of the Hospital Council of San Diego County, died February 26 at the age of 63 years. **Mrs. Ola Arrington** has been named administrator of the hospital to succeed her husband.

Mrs. Rachel Israel, for many years administrator, Loeb Memorial Home for Convalescents, New York City, passed away in New York City following a lingering illness.

Corning Announces New Tubular Fritted Glass Filters



A new tool for filtration or gas dispersion, Pyrex brand Tubular Fritted Glass Filters offer you many important advantages. Suitable for either pressure or vacuum applications, they can be obtained in accurately controlled ultra-fine, fine, medium and coarse porosity.* The connection is corrugated to accommodate several sizes of rubber tubing, making set-ups easy. Inspection for cleanliness is simplified by the clear bottom.

Made entirely of Pyrex brand glass No. 7740, Corning Tubular Fritted Glass Filters prevent contamination, eliminate absorption of active ingredients. Fired to uniform hardness, you have no trouble with particles sloughing off. They are available in three sizes: $\frac{3}{8}$ " diameter by 2", $\frac{3}{8}$ " by 4" and 1" by 8"—dimensions of effective outside fritted section.

For all-around filtration, gas washing and gas absorption, Corning's complete line of Pyrex brand Fritted Glassware will answer most of your requirements. It is available in a wide variety of standard shapes and sizes and in five porosities. For accurate analysis and long service life specify Pyrex brand Fritted Glassware. Your laboratory dealer stocks it.

*For technical information regarding flow rates and pore sizes of Fritted Glassware, write for Bulletin B-80.



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SOAPS ECONOMICAL IN USE!

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PALMOLIVE—liked by everybody—meets the highest hospital standards in purity and mildness—a favorite with patients and nurses alike!



CASHMERE BOUQUET is a big favorite in private pavilions because women like the delicate perfume of this hard-milled pure luxury toilet soap.



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NEWS...

No Funds—Hospital Closes

NEW YORK.—The Bronx Maternity and Women's Hospital here was closed recently for lack of funds to make necessary repairs, Louise M. Wagner, superintendent of the 32 bed institution, reported. Hyman Goldman, chairman of the hospital board of governors, said that \$50,000 was needed to make repairs ordered by city health, fire and building departments. Until this amount is available, the hospital would remain closed, he said.

THE BOOKSHELF

THE HOSPITAL HOUSEKEEPER'S HANDBOOK. By Stella Heinze. Winston-Salem, N.C.: North Carolina Baptist Hospital Association. \$1.25. 1949.

One of the outstanding needs of the hospital housekeeping field has been a good, practical, well written handbook to assist the executive housekeeper in

coordinating her department with the hospital as a whole. Stella Heinze, in "The Hospital Housekeeper's Handbook," has supplied a practical guide which should be in the library of every executive housekeeper for ready reference.

The functions of the housekeeping department are defined in clear, concise language, and the book contains many helpful suggestions for solving the problems that are forever arising in this particular field.

The various charts, budget estimates, linen inventories, laundry reports contained in this handbook have been carefully worked out to form a workable guide for the executive housekeeper in her effort to have an efficient, smoothly running department.

The chapters of this handbook dealing with personnel problems, linen, floor maintenance technic, time and motion study, and use of color in hospitals are particularly interesting and timely.

"The Hospital Housekeeper's Handbook" reflects Stella Heinze's many hours of untiring labor and years of experience in the hospital housekeeping field and she will be blessed by many a harassed housekeeper who will use her book many times as problems arise in daily tasks.—MARIE L. OLSEN, executive housekeeper, St. Luke's Hospital, Racine, Wis.

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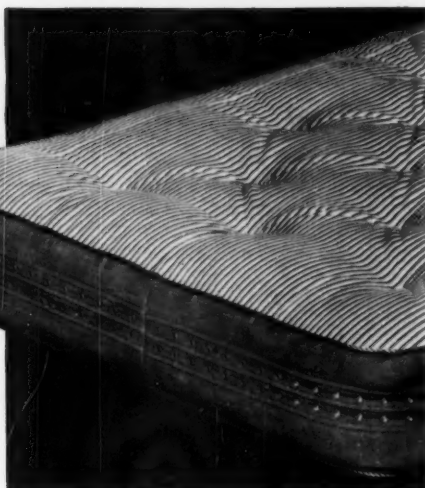
Safe • Gentle • Economical

DRUG RESEARCH AND DEVELOPMENT.

By Austin Smith, M.D., and Arthur D. Herrick. Pp. 608. New York: Revere Publishing Company. Price: \$10.

This excellent book accomplishes its purpose in that in its chapters we have collected for the first time an authoritative series of articles on the testing and marketing of drugs. The articles are well written and provide an instructive postgraduate course for presidents, vice presidents, research directors, and patent attorneys of the numerous small drug firms which have been started since the 1938 Food, Drug and Cosmetic Act was passed. The book stands as a landmark in portraying the successes and the necessary controls which have been adopted by American free enterprise in order to safeguard the public.—C. C. PFEIFFER, M.D.

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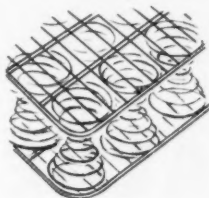


a proud achievement of mattress design and construction that carries **A 12 YEAR GUARANTEE**

No other mattress — specifically designed for hospital use offers these extras in Economy . . . Comfort . . . Long Life . . . and these NEW BIG THREE features!

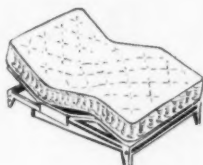
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PERM-A-LATOR insulation between springs and sisal padding and felt layers eliminating any "coil-feel", adding new flexibility, durability and smoothness to the unit.



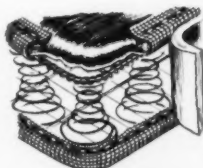
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SPRING UNIT with 200 "Premier" Tempered Spring Wire Coils. Special hour-glass shaped coils in 25 separate rows, firmly held to PERM-A-LATOR give complete body contour support, bouyant comfort, and a strong yet resilient flexing character to each mattress.



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INNER ROLL Construction which permanently machine-staples felt layers, sisal padding, PERM-A-LATOR insulation and scrim into a firm rolled-edge. This feature assures the permanence of shape, the firmness of the mattress perimeter, and increases the no-sag qualities.



Administrators:

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Their PLUS VALUES lower your costs . . . decrease maintenance expenses . . . assure you of at least 12 years Superl. Service.

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Plus 12 Years Guarantee . . . a guarantee of materials . . . construction and Hard Mfg. Company workmanship — famed since 1876 for quality craftsmanship.

Plus These features of design and construction which have made HARD bed products leaders in life long service . . . low cost maintenance and patient-comfort.

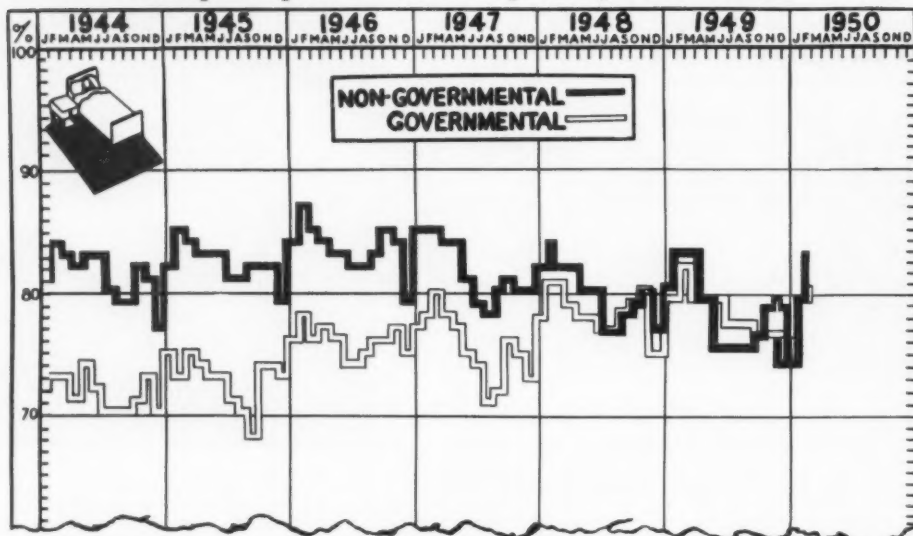
- The highest grade felt padding used.
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Made in standard 36" width by 76" length and other sizes to fit all springs.

LIFE LONG 12 can serve you best . . . ! Order from your Selected HARD Surgical Supply Dealer. For his name and all information and quotations . . . write . . .



Occupancy in Voluntary Hospitals Rises



Occupancy of nongovernmental hospitals reporting to the Occupancy Chart in February was 83.5 per cent of capacity, up 0.2 per cent over the figure reported for February a year ago. Government institutions reporting were 80.6 per cent

occupied in February—slightly below last year's figure.

Construction reported for the latest period totaled \$44,638,924, more than twice the total for the same period in 1949. Of 37 construction projects re-

ported for the period, 14 were new hospitals costing a total of \$18,334,500; 22 were additions totaling \$26,511,760, and one was a nurses' home costing a reported \$345,000. Construction total for the year to date was \$164,551,129.

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Dollar for dollar, Witte Diesels are the best power investments you can make. They'll deliver reliable power for a few cents an hour . . . year in and year out.

Witte Diesels start at the touch of a button, operate on low-cost diesel fuel, and require only a minimum of maintenance. You don't have to be a diesel expert to operate and service them.

Witte Diesel Power Units are offered from 4 to 12 H.P. And Witte Dieselectric Plants . . . a package unit consisting of a Witte Diesel and a direct-connected or belted constant voltage generator . . . range from 3 to 10 KVA-AC; 2.4 to 8 KW-DC.

Specify the type of unit and the horsepower or KVA you need. We'll send you specifications, prices and the name of your Witte dealer.

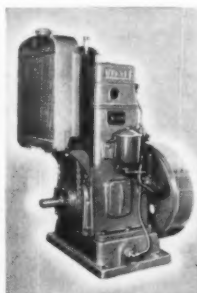
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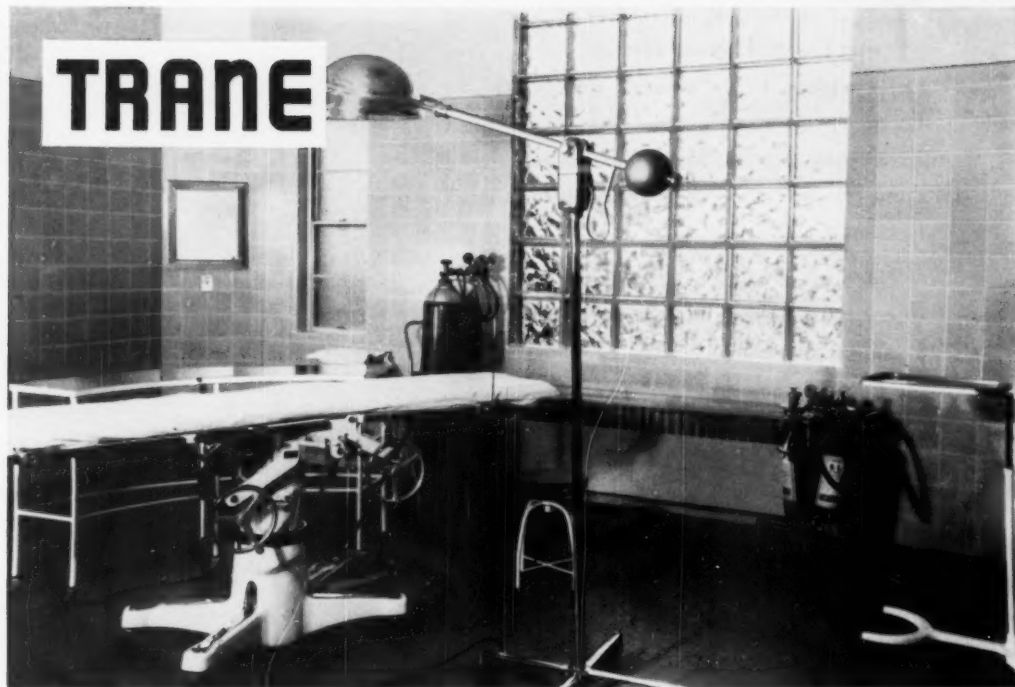


Witte Diesel Power Unit
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Efficient Trane Convectors spread comfortable warmth throughout each room—quickly—uniformly from floor to ceiling. Cool air is drawn in below the convector, instantly warmed by the compact heating element and then distributed to even the remotest corners of the room—gently and without danger of drafts.

Rooms are cleaner—hospital clean—because convector heat is cleaner heat. Modern Trane Convectors are designed to eliminate inaccessible points where dirt and dust collect.

Trane Convectors fit snugly out of the way under windows. They can be painted to harmonize with any scheme of decoration—adding a note of cheery comfort to each room. They can be installed free standing, wall hung, semi-recessed or completely recessed into the wall.

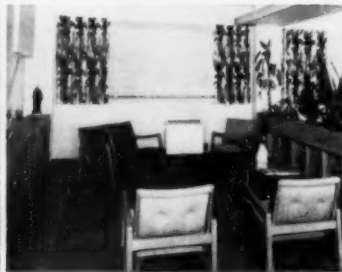
Economical too! Because Trane Convectors come in a wide range of types and sizes to fit any steam or hot water system. They cost less to install, cost less to maintain. No heat is wasted because convector heat is steady—even—controlled heat.

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TWO outstanding advantages of decorating with Lyt-all Flowing Flat and Solidex are: (1) Freedom from "painty" odor, and (2) Economy of maintenance. These, and other advantages, account for the increasing use of these fine wall coatings in hospitals from coast to coast.

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The secret is a clever hinge arrangement—plus a muntin, a glass panel and a metal panel. This same beautiful Fenestra* Hollow Metal door can be used: Swing-in or swing-out . . . left or right hand—each with panels of metal or glass . . . with or without a muntin.

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For complete details and prices, get in touch with your hospital supply dealer or, write Simmons Company, Merchandise Mart, Chicago 54, Illinois.



Patient using the tilting top as a book rest. Note ample area for large magazines. Inset shows how patient easily can change height by moving counterbalanced top up or down.



Contented patient using the deep removable tray and large, tilting mirror as a vanity table. Inset shows the large mirror, which may be used from either side of table.



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Such a program, of course, requires a very careful selection of equipment. Sheets, particularly, must be exceptionally long-wearing yet remain comfortably soft. Utica sheets meet these rigid requirements and have long been serving this institution that serves the City of New York.



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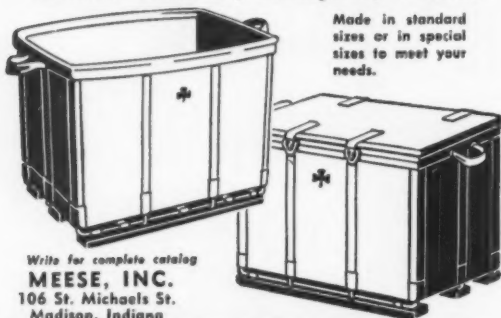
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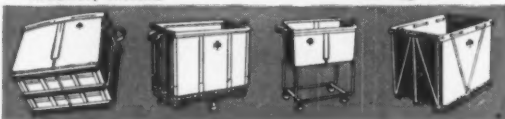
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ANOTHER LAWSON ASSOCIATES SUCCESS



Divine Providence Hospital, in Williamsport, Pennsylvania, which will open its doors in 1950.

TWO SUCCESSFUL LAWSON CAMPAIGNS RAISED \$1,390,000 FOR THIS NEW HOSPITAL

When Divine Providence Hospital, in Williamsport, Pennsylvania, first was planned, it was visualized as a 100-bed, \$1,200,000 project. The public was asked to contribute \$700,000.

A LAWSON-directed campaign in 1945-46 raised more than \$751,000 in cash and pledges.

Construction was delayed by adverse building conditions, and plans were revised to meet the urgent hospital needs of the community. The new hospital, with more than 200 beds, would cost \$3,000,000, and the public was asked to add \$600,000 to its earlier contributions.

Again, LAWSON ASSOCIATES directed this \$600,000 "Open the Doors" campaign, which went over the top February 4, 1950, with subscriptions of more than \$645,000.

Two successful campaigns for the same new hospital within five years stand as an acid test of the integrity and sound methods of B. H. LAWSON ASSOCIATES.

LAWSON ASSOCIATES campaigns are based upon (1) careful and conservative surveys; (2) expert professional direction; (3) thorough coverage of all avenues of giving.

The LAWSON ASSOCIATES methods which produced these and other successful hospital campaigns, are described in our brochure, "Fund Raising."

Write today, for your copy, to Department F-4

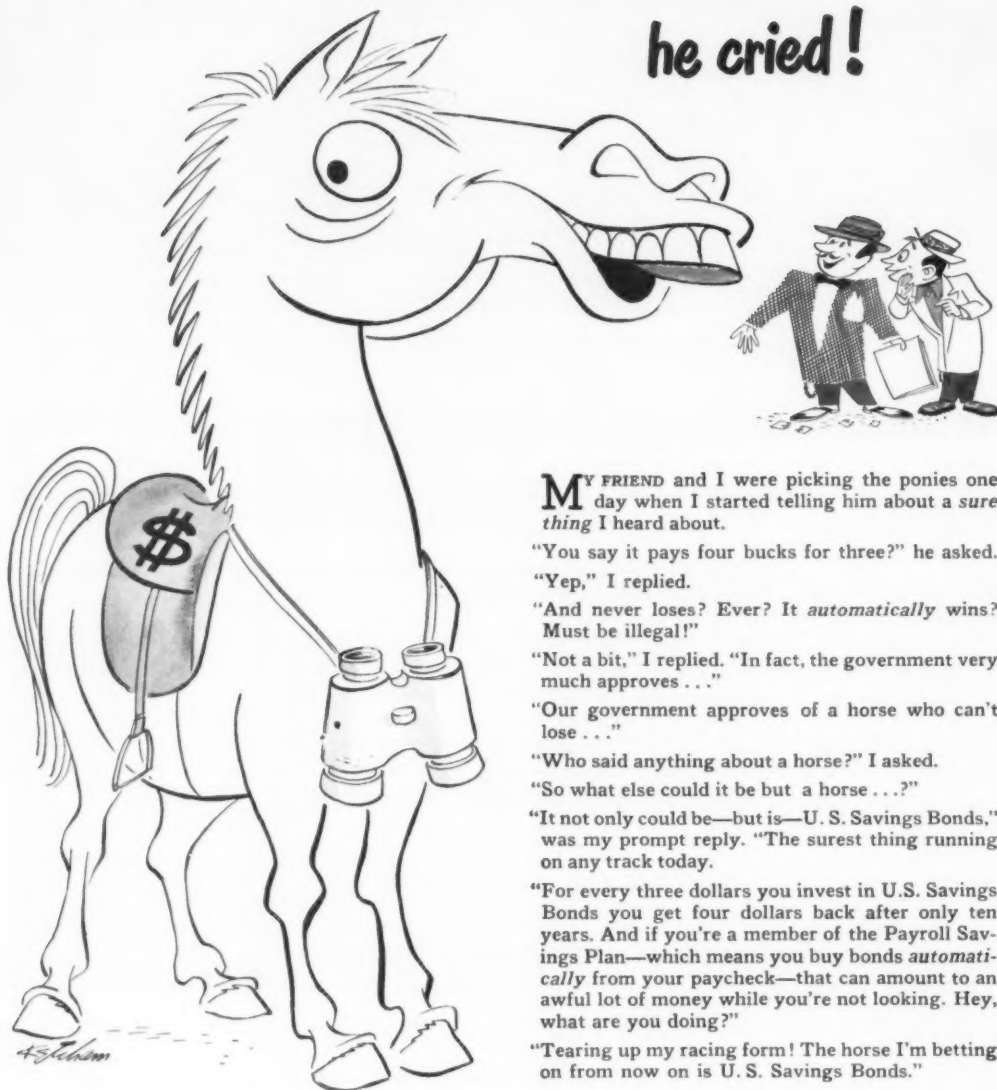
B. H. LAWSON ASSOCIATES

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ROCKVILLE CENTRE, NEW YORK

"There's no such animal," he cried!



MY FRIEND and I were picking the ponies one day when I started telling him about a *sure thing* I heard about.

"You say it pays four bucks for three?" he asked.

"Yep," I replied.

"And never loses? Ever? It *automatically* wins? Must be illegal!"

"Not a bit," I replied. "In fact, the government very much approves..."

"Our government approves of a horse who can't lose..."

"Who said anything about a horse?" I asked.

"So what else could it be but a horse...?"

"It not only could be—but is—U. S. Savings Bonds," was my prompt reply. "The surest thing running on any track today."

"For every three dollars you invest in U.S. Savings Bonds you get four dollars back after only ten years. And if you're a member of the Payroll Savings Plan—which means you buy bonds *automatically* from your paycheck—that can amount to an awful lot of money while you're not looking. Hey, what are you doing?"

"Tearing up my racing form! The horse I'm betting on from now on is U. S. Savings Bonds."

Automatic saving is sure saving—U.S. Savings Bonds



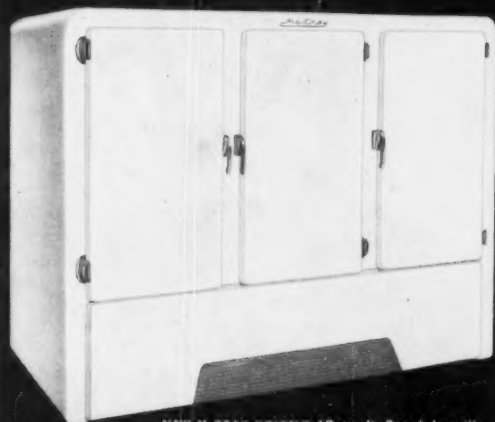
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How many salads can you handle at the rush hour? Or desserts?



NEW McCRAY KOLDFLO 40 cu. ft. Reach-In features special rack to accommodate 36 trays . . . has ample storage space for vegetables, canned goods, etc.



NEW McCRAY KOLDFLO 60 cu. ft. Reach-In will hold 48 trays. Center storage compartment has four removable-adjustable metal bar shelves.

Also available in 20 and 30 cu. ft. capacities and in both solid and glass service doors.

● Some of you will find the answers on old menus . . . with items crossed off at the height of the rush hour. Others can check in countless ways . . . a loss of customer patronage . . . a sharp word of criticism.

What is important is that so often this problem of rush-hour confusion can be remedied by efficient refrigeration. Many a commercial kitchen has been completely reorganized around one or more McCray Koldflo Reach-Ins. And the reduction of waste and lost time has been tremendous.

McCray Koldflos offer controlled refrigeration—a perfect balance of circulation, temperature and humidity. What's more, cold air rises up from under food trays and dishes . . . never blasting food surfaces, a real factor in spoilage.

There are many outstanding service features in every McCray Koldflo . . . many points of construction that explain the amazing service and long life of these Reach-Ins. Ask your McCray dealer about them. Or write for full information to the McCray Refrigerator Company, 1066 McCray Court, Kendallville, Ind. (Distributors in principal cities—see telephone directory.)

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KOLDFLO

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"fresh up"
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THE ALL-FAMILY DRINK!

When Dad buys 7-Up by the case, there are even bigger smiles all around. That's because sparkling, clean-tasting 7-Up is truly the favorite family beverage . . . favorite of every age.

*So pure... So good...
So wholesome
for everyone!*



You like it... it likes you!

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Make your own inset arrangements with this new

"DIET-THERAPY" FOOD CONVEYOR

Engineered by

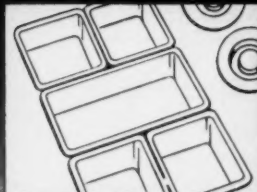
PROMETHEUS



ONE conveyor gives you complete control of your selective menus

Innumerable top-deck variations are yours with this "diet therapy" food conveyor. You simply arrange the various size rectangular and square insets to fit the specific needs of your selective menus. In addition, there are two round wells for soups, etc., and two heated drawers for bread and rolls. Other models available with additional round wells.

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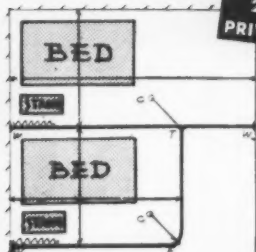


Write today for full details on the "Diet Therapy" Food Conveyor and literature describing our complete line of food serving equipment.

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\$45



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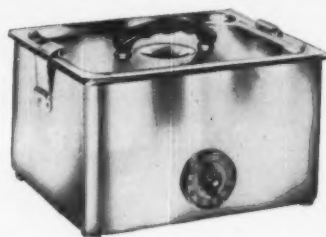
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THE new Scott Demand Inhalator provides an easy, low-cost method of oxygen administration for fixed-base installation or portable use. It supplies oxygen at any rate and any volume "demanded" by the patient, with constant flow also available "at the touch of a button."

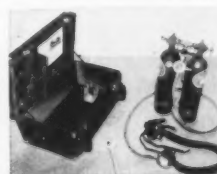
Simple to use, the new Scott Demand Inhalator cuts training time to a minimum. No adjustments of any kind—no need to wait for the "expert" in emergency cases.

The Scott Demand Inhalator is not only economical in use, but is available at a cost far below that of equipment of comparable scope. It is truly the low-cost way to handle oxygen administration. See your distributor, or write for full information today to:



Above illustration shows Scott TYPE "A" Demand Inhalator in use, connected to large oxygen cylinder.

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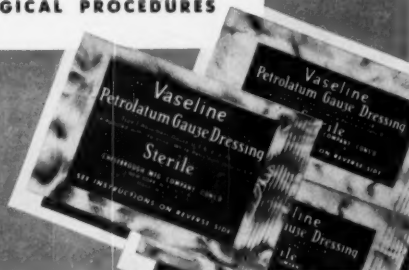
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Unopened Bejectal is stable indefinitely. When mixed the solution contains:

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Riboflavin..... 20 mg.
Nicotinamide..... 750 mg.
Pyridoxine Hydrochloride... 50 mg.
Calcium Pantothenate..... 50 mg.
In Water for Injection, U.S.P.

Benzyl Alcohol, 0.9%, is added as a preservative since the mixed solution is for multiple doses.

MIXED • • • STABLE—Up to two months

This is the best way to prepare Bejectal when you expect to use the entire 10 cc. within 2 months. Simply withdraw 4 cc. of the contents from the small vial with a sterile syringe and transfer to the large vial. Shake the large vial and Bejectal is now ready for use.



UNMIXED • • • STABLE—Indefinitely



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Now also milk diffusible

10,000 units of vitamin D, 50,000 units of vitamin A per gram. Bottles of 10 cc. and 50 cc.

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YOUNG

AT

SIXTY?



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CARBOHYDRATE	65 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12 mg.	COPPER	0.5 mg.

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



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Saves valuable operating time

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The Dermatape loses its adhesion to

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Complete with stand and one set of
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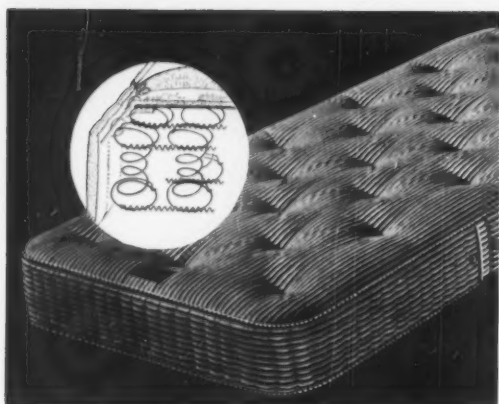
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For detailed information see our Catalog in 1949-1950 HOSPITAL PURCHASING FILE

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Reflector may be inverted for indirect room lighting

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Especially designed for patient's seeing comfort and hospital convenience

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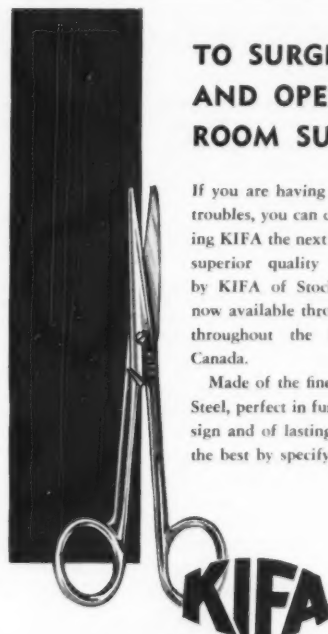
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Made of the finest Swedish Stainless Steel, perfect in function, correct in design and of lasting quality—you'll get the best by specifying KIFA.



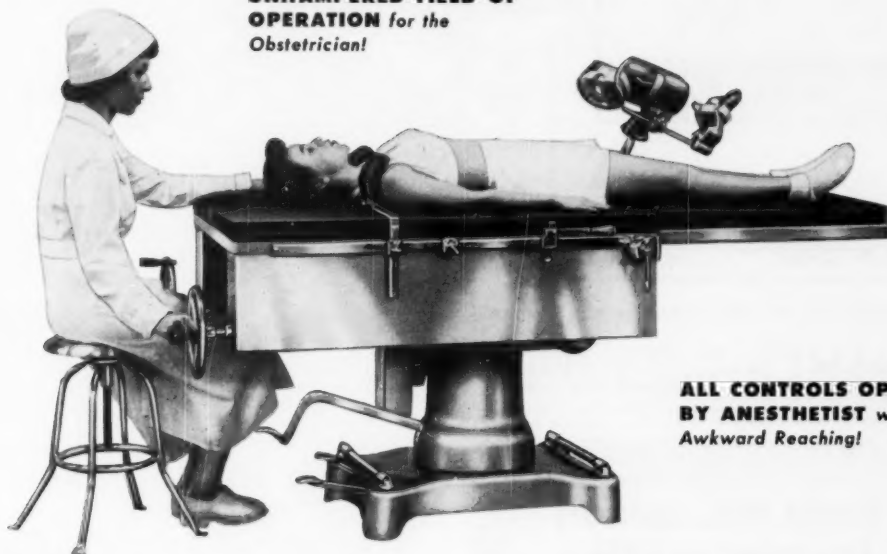
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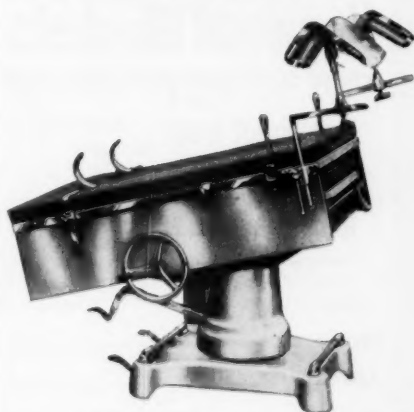
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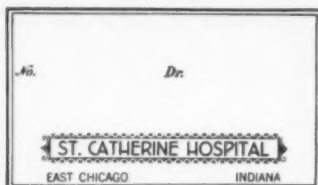
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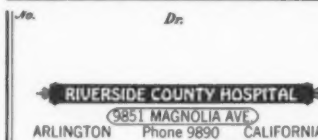
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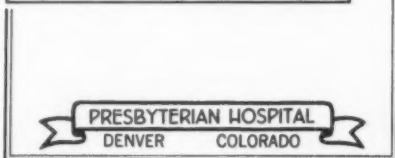


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You may never have time to look into your floor expenses. But just ten minutes thumbing through our booklet, *Mr. Higby Learned About Floor Safety the Hard Way*, would tell you that all four of the above statements are *False* . . . and why. This book wastes no time on details. It hits the highlights; briefs you on the important considerations that every executive should know to account for floor expenses.

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New Broom, New Technique Cuts Floor Sweeping Time

A new broom-type instrument that cleans in a new, more thorough manner, is now available to reduce sweeping time in hospital corridors and ward rooms.

Called the Damp-Sweep Tool, the instrument is designed to pick up fine dust and grit that cannot be removed by conventional brooms. It features a handle with all-directional swivel that gives the instrument great maneuverability and reduces waste motions in sweeping.

As its name implies, the Damp-Sweep Tool is designed for damp-sweeping—a technique in which a dampened cloth is used under the broom. This technique has proved superior to brush sweeping for removing fine dust from floors, and preserving the finish from soiling. The Damp-Sweep Tool is the first instrument created specifically for damp sweeping.

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To sweep, the instrument can be walked in long, straight strokes or swung in wide arcs. The swiveled handle permits a sweeper to manipulate the instrument in arcs, under furniture and around obstructions with a twist of the wrist. Whole areas are swept without a break in stride or sweeping rhythm, and sweeping time is reduced as much as one-third.

The Damp-Sweep Tool is available to hospitals only through sales offices of the Walter G. Legge Co., Inc. For full details, write "Damp-Sweep Tool" in the coupon to the left, clip to your letterhead and mail.

Want Advertisements

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ADMINISTRATOR—Age 39; fourteen years' experience public health and hospital administration; Public Health Degree; formally trained hospital administration; currently employed as assistant director, teaching hospital. MW 98, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Experienced: of a 70-bed private hospital; with an excellent record for making money; is seeking a better connection. MW 1, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Layman, middle forties; successful record hospital management, 20 years; strong on finances, organization, public relations; seeks post, progressive medium size hospital, east. MW 100, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Middle thirties; nominee, ACHA; M.S., Hospital Administration; four years' top level administration, several years minor administrative posts; considerable purchasing, expansion, maintenance and budgetary success; available July 1st. MW 99, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Retired army officer; Fellow, American College Hospital Administrators; administrative experience in civil hospitals; desires position west or south; available now. MW 85, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—With fifteen years' experience all types anesthesia; given over several thousand cases curare, sodium pentothal. MW 27, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSING—General hospital; graduate staff; Infinity New York City, Long Island or Philadelphia area; 5 years' director nursing; 4 years' assistant. MW 97, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

BOOKKEEPER—Capable woman experienced in small hospital routine, admitting, PRX, collecting and general office work; interested in either general or mental hospitals; anywhere in the western states. MW 96, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

LAUNDRYMAN—With board and room; good health; over 30 years' experience; can manage small laundry. MW 88, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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PATHOLOGIST—Certified; three years' Fellowship Pathology, Mayo Foundation, eighteen years experience excellent hospitals; available now.

RADIOLOGIST—Age 38; Diplomate American Board, member American College of Radiology, two year Fellowship Radiology, University of Minnesota; excellent experience; available now; prefers southwest; recommended highly.

DIRECTOR OF PHYSICAL MEDICINE—Age 37; seeks position as director of physical medicine and rehabilitation with either hospital, industry or insurance organization; certified 1947; excellent background of training and experience; immediately available.

NURSE ANESTHETIST—Age 38; approved 9 month course; experience includes five years' United States Army; several years' superintendent of nurses and anesthetist smaller hospital; interested locating southwest or Alaska; American Association Nurse Anesthetists.

DIRECTOR OF NURSES—Ph. B., M.S.; experience includes ten years' director nurses large Chicago hospital; also assistant dean, Cook County Hospital, Chicago; seeks southwest; available June; highly recommended.

DIETITIAN—ADA; 46; single; experience includes 4 years', chief and director dietetics, 500-bed eastern hospital; 4 years', director of nutrition, 500-bed general hospital; Major in Institutional Management; completing Master's this month; will teach; prefers home economics or food nutrition; prefers New York area; \$350 and maintenance.

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MEDICAL OR SCIENTIFIC ILLUSTRATOR—Female; age 27; two years' experience as medical artist; college graduate; consider any desirable location; good references.

(Continued on page 216)

THE MEDICAL BUREAU
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ADMINISTRATOR—A.B., eastern university; year's graduate work, sociology and statistics, Harvard; M.S., Hospital Administration, Columbia; year's administrative internship and two years, assistant superintendent, 500-bed hospital; prefers administration hospital, 100-125 beds, or assistantship in larger one.

ADMINISTRATOR—Degree in Business Administration; six years' administrator, 200-bed hospital; since 1940, director, 350-bed hospital; excellent experience in modernization, enlargement and planning of hospital facilities, fund raising, public relations; FACHA.

ADMINISTRATOR—Graduate nurse; B.A., B.Sc., Nursing, M.B.A., Hospital Administration; five years' business experience, private secretary, before entering school of nursing; five years', assistant administrator, 450-bed hospital.

MEDICAL ADMINISTRATOR—B.S., M.D., one of country's leading universities; two-year residency in medicine; three years' assistant director, large voluntary hospital; five years', administrator, 250-bed hospital; FACHA.

ANESTHESIOLOGIST—Diplomate, American Board; experience includes four years', associate department, anesthesiology, 400-bed hospital; five years', chief of department of anesthesiology, 300-bed hospital.

SOCIAL WORKER—Master of Science in Social Administration; three years', family case worker; past several years', chief medical social worker, teaching hospital.

PATHOLOGIST—Diplomate, Pathologic Anatomy, Clinical Pathology; five years', director, laboratories, 400-bed hospital; eight years', professor of clinical pathology and pathologist to teaching hospital; considered one of leaders in the field.

RADIOLOGIST—Diplomate, American Board; Fellow American College of Radiology; seven years', director, radiology, 300-bed hospital; now radiologist, group limiting practice to radiology; prefers directorship of hospital department.

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BUSINESS MANAGER—C.P.A. Degree, western university; 15 years' experience as auditor; just completed 4 year term, 300-bed hospital; recommended for reorganization ability.

ADMINISTRATOR—Age 40; courses in Hospital Administration, Columbia University; 10 years' assistant superintendent, 300-bed eastern hospital; 5 years director, 150-bed Ohio hospital; prefers south.

ADMINISTRATOR—B.A. Degree, eastern university; Major, Hospital Administration; 2 years' administrative assistant; at present, director 100-bed hospital; experienced in directing fund raising campaigns.

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POSITIONS WANTED

INTERSTATE—Continued

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PERSONNEL & PUBLIC RELATIONS DIRECTOR—Young college graduate; 3 years' successful experience, 200-bed hospital; highly recommended.

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Blanche L. Shay, Director
55 East Washington Street
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ADMINISTRATOR—Age 37; Master's Degree in Business Administration; served administrative internship in large eastern hospital; eligible for membership in American College of Hospital Administrators; 10 years' hospital experience in capacities of: administrator, superintendent, personnel director; past four years' administrator of 468-bed hospital; immediately available.

ADMINISTRATOR—Registered nurse; 20 years' experience as superintendent with five large eastern hospitals; very successful record; age 48; member, American College of Hospital Administrators; available immediately.

SHAY—Continued

ASSISTANT ADMINISTRATOR—Age 35; Master's Degree in Hospital Administration; A.B. Degree in Business Administration; Administrative internship in large hospital on Pacific Coast; well qualified young man; excellent material for development in administrative capacity; will go anywhere; available at once.

POSITIONS OPEN

ANESTHETIST—Graduate nurse; in a modern well-equipped 200-bed Michigan hospital, located in lake area in close proximity to metropolitan Detroit; five anesthetists on staff; \$285 base pay with \$10 step increases at 6, 12, 24 and 36 months; excellent cafeteria meals; uniforms laundered. Write Director, Pontiac General Hospital, Pontiac, Michigan.

ANESTHETIST—For 40-bed hospital located in small city of 5,000, only 80 miles south of Chicago; good transportation to Chicago; salary \$300 per month plus meals and laundry of uniforms; send full particulars. Apply Administrator, Iroquois Hospital, Watseka, Illinois.

ANESTHETIST—Nurse; for 300-bed hospital; four anesthetists now on service; salary open. Apply, D. W. Hartman, Superintendent, The Williamsport Hospital, Williamsport, Pennsylvania.

ANESTHETIST—Nurse; one; 150-bed hospital; \$300 per month and full maintenance; department directed by medical anesthetist; state experience. Apply to Director of Anesthesia, St. Francis Sanitarium, Monroe, Louisiana.

ANESTHETIST—Nurse; registered; for general hospital; 38 beds; salary \$250 per month, full maintenance; vacation and sick leave. Apply, Superintendent, Nantucket Cottage Hospital, Nantucket Island, Massachusetts.

ANESTHETIST—Nurse; for fully approved 200-bed hospital; salary and maintenance; if two wish to work together, they will both be considered. Apply, R. J. Crotty, Director of Anesthesia, Luther Hospital, Eau Claire, Wisconsin.

ANESTHETIST—Preferably registered; \$400, maintenance; 56 miles from Washington, District of Columbia. Apply, Superintendent, St. Mary's Hospital, Leonardtown, Maryland.

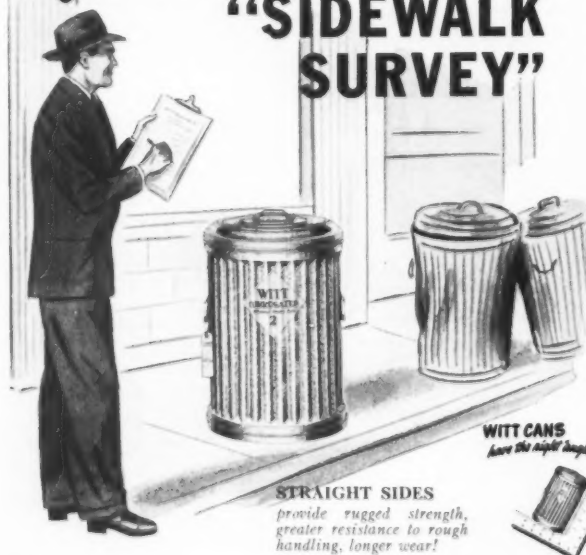
DIETITIAN—Assistant; wanted for 200-bed tuberculosis hospital; good salary plus room, board and laundry; please send small photograph or snapshot with letter of application stating qualifications and pertinent personal details. Apply Superintendent, Indiana State Sanatorium, Rockville, Indiana.

DIETITIAN—Chief; to have full charge of dietary department of 75-bed hospital. Apply, Mrs. Stewart Roberts, Medical Placement and Mailing Service, 768 Juniper Street, Atlanta, Georgia.

DIETITIAN—Pediatric; Raymond Blank Memorial Hospital for Children; 112 beds; children's hospital affiliated with Iowa Methodist Hospital; position includes responsibility for formula room and three serving kitchens; new hospital; best of equipment; dietary department of six ADA dietitians; salary open. Write, Chief Dietitian, Iowa Methodist Hospital, Des Moines, Iowa.

(Continued on page 218)

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STRAIGHT SIDES

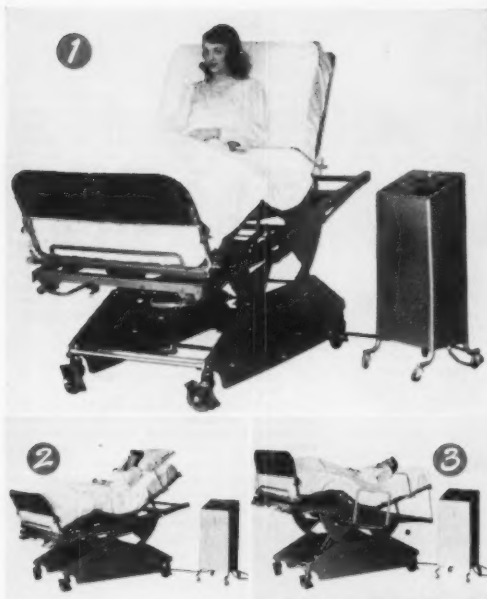
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QUALITY ASSURING GUARANTEE—WITT Cans outlast ordinary cans 3 to 5 times.

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"Originators of the Corrugated Can"



(Photo No. 1—Inhalation Completed. Photo No. 2—Exhalation Started. Photo No. 3—Exhalation Completed. Respiratory cycle is from Photo No. 1 to Photo No. 3 and back to Photo No. 1. Speed and angle of oscillation is regulated by controls on instrument at right.)

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DIETITIAN—300-bed hospital; modern department; opening for either assistant administrative or therapeutic; therapeutic includes teaching in nursing school; salary \$2100 plus complete maintenance. Apply Administrator, Columbus City Hospital, Columbus, Georgia.

DIRECTOR OF NURSING AND NURSING SERVICE—Midwest hospital currently expanding to 200-bed capacity; active school of nursing, three year program with enrollment of 80 students and competent staff of instructors; this hospital while not church owned has the active and vigorous support of Protestant churches in the community; this hospital emphasizes friendly and considerate care of patients; attractive salary; degree necessary. MO 76, The Modern Hospital, 919 N. Michigan Avenue, Chicago, 11.

INSTRUCTOR—Nursing arts; position open any time after May 1, but must be filled before September, for 80-bed hospital; school of nursing opened September, 1948. Apply, Director of Nursing, Pulaski Hospital, Pulaski, Virginia.

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LIBRARIAN—Chief medical record; for university hospital; must be registered and experienced in both clinic and private record room operations; must have supervisory ability; general hospital of 400 beds and outpatient department with yearly census of 116,000 visits. Apply, Personnel Department, Stanford University Hospitals, Clay and Webster Streets, San Francisco 15, California.

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MISCELLANEOUS—Nursing arts instructor; Educational director; Operating room supervisor, needed at once; immediate opening; good location; State Capitol with many civic advantages; salary open. Apply Director of Nurses, Evangelical Hospital, 6th and Thayer, Bismarck, North Dakota.

MISCELLANEOUS—Operating room supervisor and night obstetrical nurse; for 55-bed general hospital; salary open; full maintenance in nurses' residence; vacation and sick leave; college city, population 10,000. Apply, Superintendent, Jane Case Hospital, Delaware, Ohio.

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NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shift; average gross cash salary \$200 to \$210 month; full maintenance available for \$10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

(Continued on page 220)

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A SOFT PLIABLE Bracelet Contains Patient's Name

(Permanently attached to patient's wrist)

FOR BOTH INFANTS AND ADULTS...

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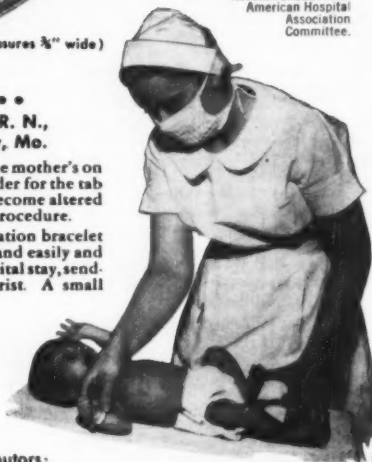
We attach the baby's identification bracelet in the Delivery Room quickly and easily and leave it on throughout the hospital stay, sending it home on the baby's wrist. A small charge is made to the patient, but it is more inexpensive than any other bracelet we have used."



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NURSES—Registered nurses and registered psychiatric nurses; men and women; for state hospital assignments, for general duty, hospital work, tuberculosis and psychiatry; also registered psychiatric nurses with college degree as instructors of affiliating schools of psychiatric nursing; good salaries; opportunity for advancement; excellent retirement and insurance plan. Write, Division of Personnel Service, Department of Public Welfare, State Armory, Springfield, Illinois.

NURSES—2 qualified registered nurses; one for evening supervision; one for general duty; by May 1, 1950. T. J. Samson Community Hospital, Glasgow, Kentucky.

NURSES—Staff; needed for all departments in 150-bed general hospital; 41-hour week; 2 weeks' vacation with pay. Apply Director of Nursing, St. Joseph Hospital, Mount Clemens, Michigan.

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PSYCHIATRISTS—Openings for senior, assistant and junior; for staff or progressive and fully approved state hospital; excellent salary and full maintenance. Write, Superintendent, Delaware State Hospital, Farnhurst, Delaware.

RESIDENCIES—Anesthesiology; fully approved; clinical and didactic instruction in all phases of anesthesiology; university affiliation. Apply, Administrator, Evanston Hospital, Evanston, Illinois.

SUPERINTENDENT OF NURSES—For 140-bed tuberculosis sanatorium; capable supervisor or executive with experience in tuberculosis or contagious diseases required; give particulars, references and small picture if available; interview preferred; salary \$238 to

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BUSINESS AND MEDICAL REGISTRY (Agency)

Elsie Miller, Director
553 South Western Avenue
Los Angeles 5, California

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(Continued on page 222)

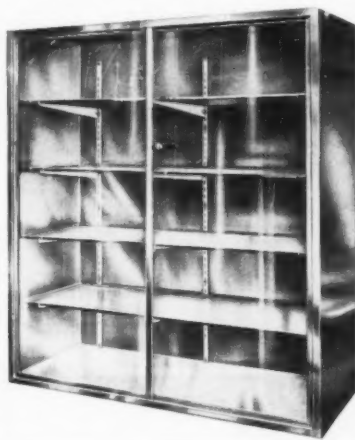
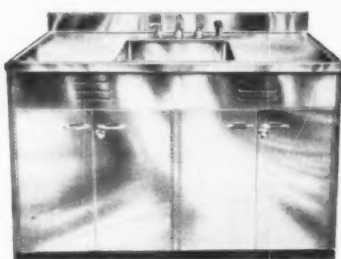
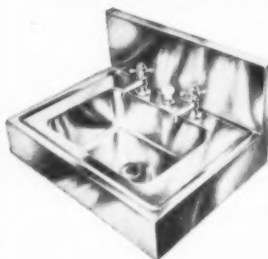
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(Continued on page 224)

WOODWARD—Continued

ADMINISTRATORS—Staff appointments. (l) Business manager; new midwest 25-bed hospital situated excellent college city, 100,000. (m) Supervisor-collection, department; 400-bed university general hospital; east. (n). Chief accountant; 100-bed general; nurses school; position holds excellent potential as 200-bed addition is being planned; Virginia.

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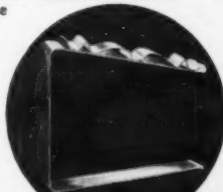
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Vol. 74, No. 4, April 1950

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WOODWARD—Continued

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WOODWARD—Continued

DIRECTOR SOCIAL SERVICE—(a) 300-bed general hospital; large city on Great Lakes; \$4000 to \$5000; no maintenance. (b) 200-bed eastern general near university medical center metropolis. (c) Consultant for resources for care of chronically ill; near important university medical center; central; to \$4000. (d) Psychiatric caseworker; large general with recognized child guidance clinic; preferably AAPSW; near important university medical center metropolis; \$3500.

INSTRUCTORS—(a) Clinical; large college affiliated general hospital; eastern city 110,000; to \$3500. (b) Nursing arts; excellent medium sized Kansas general hospital; \$325. (c) Science; fairly large Maryland general hospital; near important university medical center. (d) Clinical in psychiatric nursing; large mental hospital; to \$335; central. (e) Psychiatric nursing; position carries university faculty status; will be later appointed to excellent level in new psychiatric receiving hospital now under construction; central; \$3600, maintenance. (f) Social science; 200-bed general hospital; South Carolina.

SUPERVISORS—(a) Medical-surgical; fairly large Florida general hospital with large expansion program; excellent faculty and working conditions. (b) Nursery; average 35 patients daily; 225-bed general hospital in the Detroit area; \$3000. (c) Obstetrical; excellent brand new fairly large general hospital; responsibility entire department; will have competent staff; interesting southwest open country; \$275. (d) Operating room; new operating room suite and desirable working conditions; large general hospital near New York; \$350. (e) Pediatric; fairly large Iowa general; \$250.

(Continued on page 226)

WOODWARD—Continued

OCCUPATIONAL THERAPIST—Large tuberculosis hospital near New Orleans; \$2400, maintenance.

TECHNICIANS—(a) Senior tissue; full charge department; handle special staining; qualified in papanicolaou technique; 12 assistants; large eastern general hospital; suitable salary. (b) Laboratory supervisor; ASCP; part time spent in student instruction in approved school; large New York State general hospital; \$300. (c) X-ray; experienced in therapy work; will have experienced assistant; important western clinic; \$550.

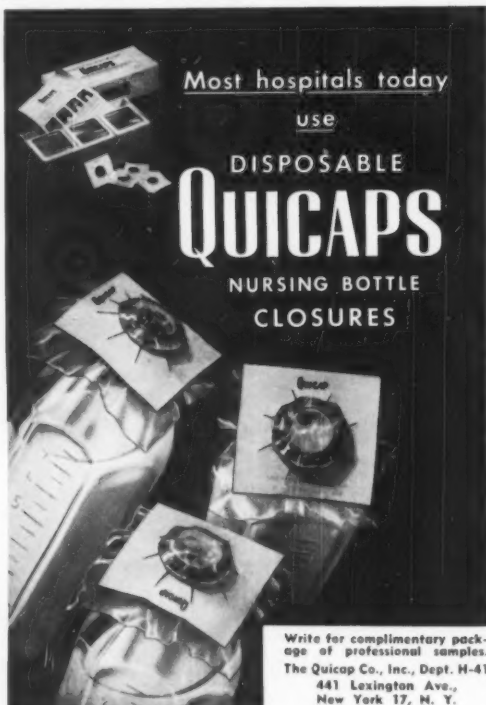
RECORD LIBRARIANS—(a) Chief; 500-bed teaching hospital with extensive expansion program now being completed; south. (b) Chief; 600-bed teaching hospital; 20 subordinates; \$4000; southeast. (c) 500-bed teaching hospital excellent warm climate; \$350. (d) Fairly large Pennsylvania hospital; \$275. (e) 250-bed general hospital; California; \$250, maintenance.

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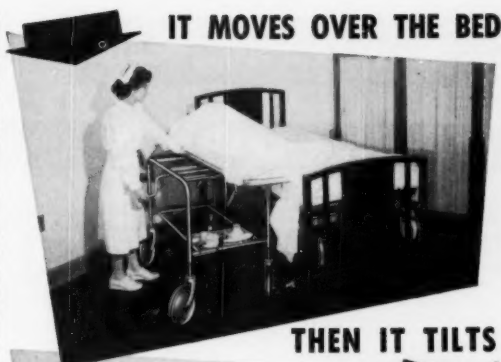
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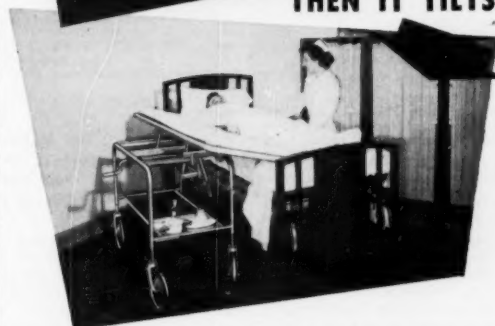
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SUPERINTENDENT OF NURSES—(a) 75-bed orthopedic hospital; large industrial city. (b) New 100-bed tuberculosis sanatorium; central state; \$3900, maintenance. (c) 200-bed children's hospital; east; affiliating students.

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INTERSTATE—Continued

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TECHNICIAN—X-ray; 125-bed hospitals; Pennsylvania, Ohio, Michigan, Illinois, Texas.

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EXECUTIVE HOUSEKEEPER—(a) Sisters' hospital; Ohio. (b) 375-bed hospital; mid-western university city; \$225, maintenance. (c) 80-bed modern hospital; West Virginia. (d) California; \$275.

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Burnice Larson, Director
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MEDICAL BUREAU—Continued

ADMINISTRATORS—(a) Medical; large general hospital; Pacific Coast. (b) Lay or medical; general hospital, 225 beds; new addition currently under construction will double capacity; New England. (c) Lay or medical; large general hospital; Rocky Mountain state. (d) Lay; general hospital, 200 beds, new wing under construction will increase capacity to 300; town of 30,000, middle west. (e) Lay or medical; voluntary hospital, 400 beds; teaching affiliations; university medical center. (f) Medical; associate directorship; university group of hospitals; preferably one with several years' experience directing large hospital. (g) Medical director to serve as chief, new division for inspection and licensure of hospitals; duties include administering Hill-Burton federal aid to hospital program. (h) Lay; 90-bed rural hospital under construction; advantageous if experienced fund raising, public relations; around \$10,000; east. (i) Hospital of small size now under construction; college town of 10,000, 20 miles from university city of 300,000; midwest. (j) Small general hospital currently under construction; residential town, Oregon. (k) Assistant administrator; 250-bed general hospital, building program to replace old buildings with new medical center; formal training in hospital administration required; although accounting background desirable, duties will involve only responsibility for the department. (l) Business manager, 125-bed hospital recently opened for operation; town of 15,000 located in mountainous area of southeast. MH4-1.

(Continued on page 228)

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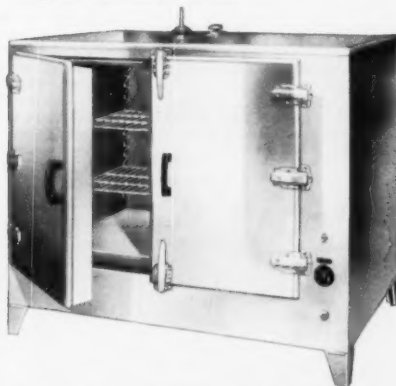


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Want Advertisements

POSITIONS OPEN

MEDICAL BUREAU—Continued

ANESTHETISTS—(a) General hospital having patient average 100; staff of four anesthetists; percentage arrangement with guaranteed minimum; large city, university center; southwest. (b) Small general hospital operated by American company in Arabia; homes, clubs, dormitories, air-conditioned. (c) Relatively new hospital; residential town located on the ocean in resort area of Pacific Northwest; \$4200, maintenance. MH4-3.

DIETITIANS—(a) Chief dietitian, also two assistant dietitians; 450-bed general hospital; large city of the south; salaries respectively \$350 and \$250, maintenance included. (b) Nutritionist to conduct state health nutrition program; graduate training in public health nutrition required; headquarters, university town; considerable travel. (c) Administrative; dietary department serving 250 patients daily in addition to cafeteria and tea room serving 1200 meals daily; university medical center, middle west. (d) Chief; fairly large hospital; Philadelphia area. (e) To take charge of department; new hospital operated by private practice group; \$3500-\$4800; resort area, southwest. MH4-4.

COORDINATOR—(a) Cerebral palsy nursery of large teaching hospital; should be able to organize and direct program; considerable experience required; \$5000. MH4-5.

MEDICAL BUREAU—Continued

EXECUTIVE HOUSEKEEPERS—(a) General hospital, 300 beds; \$250, maintenance. (b) To organize and direct central housekeeping department; teaching hospital, 350 beds; middle south. MH4-6.

DIRECTORS OF NURSES—(a) One of leading hospitals in the vicinity of New York City; hundred students; well organized medical staff; fully approved; modern personnel practices; nursing staff on 5-day week; position available summer 1950. (b) General 200-bed hospital affiliated with university school of medicine; university center, middle west. (c) Director of nurses and school; one of California's most important hospitals; much sought after location. (d) Nursing service and school; small general hospital; 40 students; college town; New England. (e) Director of nursing service and principal of school of practical nursing; large general hospital; outstanding opportunity; eastern metropolis. (f) General 300-bed hospital operated by one of country's outstanding private practice groups; woman of outstanding qualifications required; university town. (g) Small general hospital operated by famed group all-graduate staff; building program includes larger hospital; town of 10,000, winter resort area of southwest. (h) Assistant director; department of nursing, state university; expansion program; South. MH4-7.

(Continued on page 230)

MEDICAL BUREAU—Continued

EDUCATIONAL DIRECTOR—To serve as visiting representative of State Board; Baccalaureate Degree, 5 years' experience including 3 as director of nursing, required. MH4-8.

FACULTY APPOINTMENTS—(a) Educational director; general hospital, 300 beds; college affiliations; will consider one working toward Master's Degree; minimum \$4000, maintenance. (b) Instructor in nursing education; advanced clinical course; university faculty appointments; \$4200-\$5300. (c) Nursing arts and science instructors; 400-bed general hospital; new, air-conditioned residence for nurses recently completed; university city, southwest. (d) Educational director; children's unit of university center; pediatric training desirable; interesting city located outside of Continental United States. (e) Instructors in out-patient, maternity, public health and pediatric nursing; large teaching hospital; faculty appointments on university staff. MH4-9.

MEDICAL RECORD LIBRARIANS—(a) Chief; one of California's leading hospitals; outstanding opportunity. (b) Chief; large general hospital, vicinity New York City. (c) Chief; qualified to reorganize department, large teaching hospital; south. (d) Chief; one of country's leading teaching hospitals; staff of 26; minimum \$4000; east. MH4-10.

HEALTH NURSES—(a) Student health nurse; liberal arts college; administrative ability; short distance from Chicago. (b) Director of public health nursing program; outstanding opportunity with eastern university. MH4-11.



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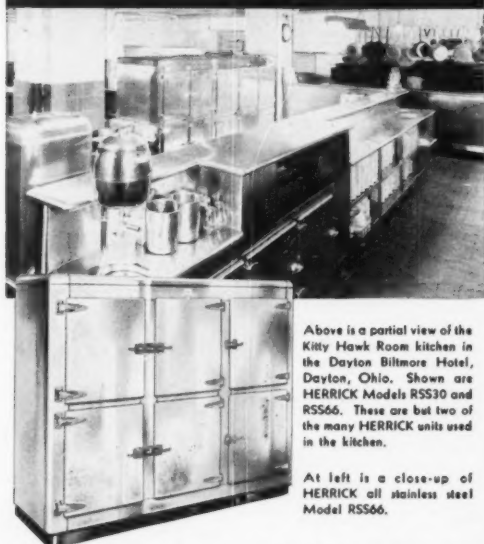
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At left is a close-up of HERRICK all stainless steel Model RSS66.

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MEDICAL BUREAU—Continued

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SUPERVISORS—(a) Pediatric, obstetrical and surgical floors; general hospital, 450 beds; new, air-conditioned residence recently completed; university city of 300,000, southwest. (b) Operating room; general, 350-bed hospital; metropolitan area of east; \$4200. (c) Administrative; new psychiatric-psychosomatic unit of teaching hospital, 80 beds; large city, middle west. MH4-13.

STAFF NURSES—General duty and surgical nurses; general hospital operated by American company in Arabia; homes, dormitories, clubs air-conditioned. MH4-14.

TECHNICIANS—(a) Chief technician and, also, staff technician; relatively new hospital, 200 beds; California. (b) Chief x-ray technician; duties include teaching; \$3500-\$4800. (c) Occupational therapist; private hospital for mild mental diseases; residential town in Connecticut, short distance from New York City. (d) Physical therapist; new hospital, 200 beds; town of 75,000, Rocky Mountain state. (e) Chief laboratory technician; new hospital operated in Arabia under American auspices; \$4000, maintenance. MH4-15.

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(Continued on page 232)

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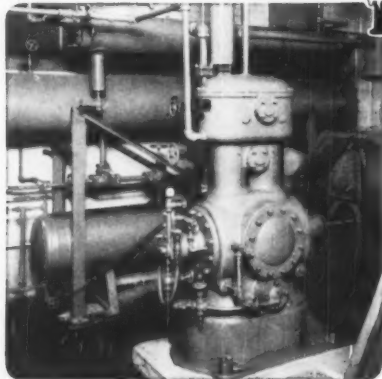
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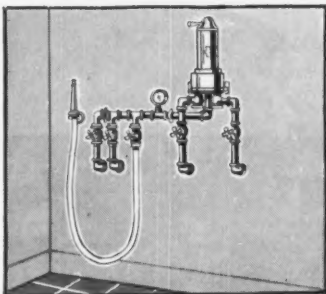
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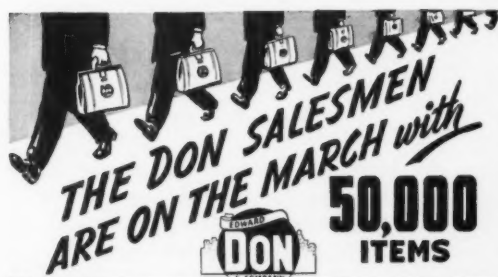
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(Continued on page 234)

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(Continued on page 236)

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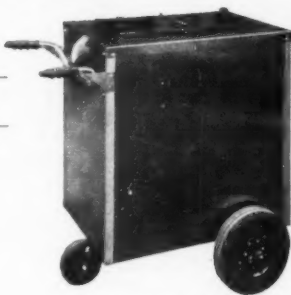
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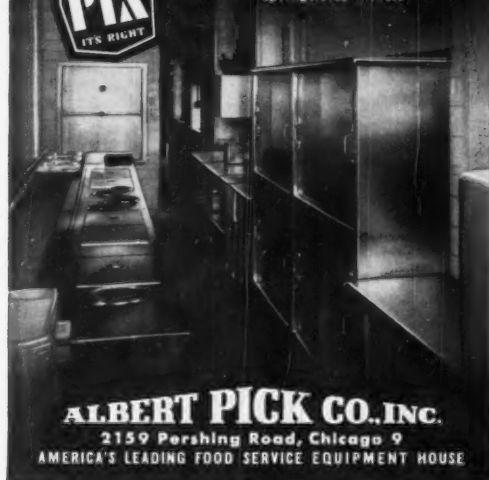
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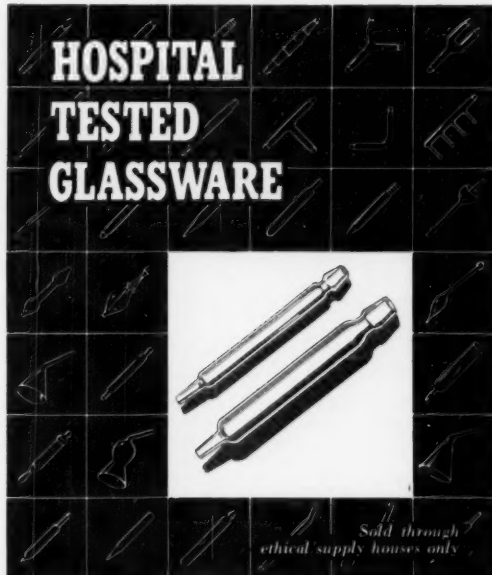
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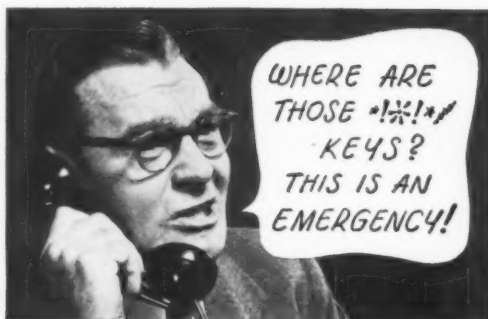
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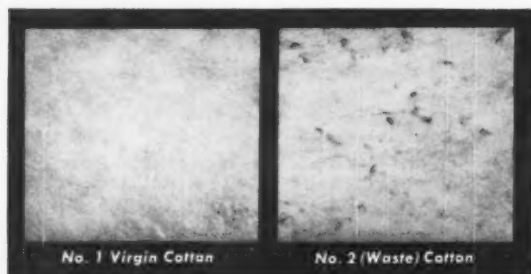
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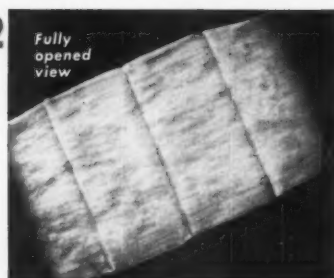
TRADE MARK

1



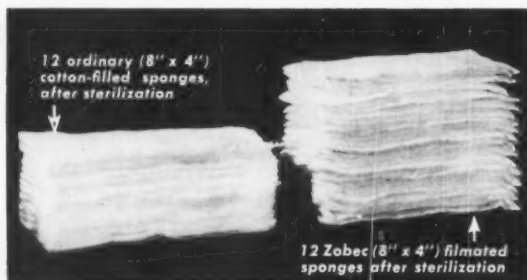
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2



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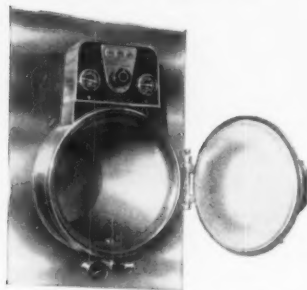
Johnson & Johnson
HOSPITAL DIVISION

What's New for Hospitals

APRIL 1950

Edited by BESSIE COVERT

All-Welded Sterilizer



All-welded construction is now provided in American sterilizers, thus eliminating the use of rivets and solder. The new method of construction, with forged Monel end rings, provides greater strength with permanent resistance to rust, leaks and corrosive damage. A smooth surface without crevices is another important advantage of the all-welded construction.

The gasket is now on the door in the new sterilizer, thus permitting it to cool when the door is open. This new feature increases the life of the gasket since it is not constantly subjected to deteriorating heat. Welded, forged end rings of solid Monel are now standard on all 16 and 20 inch cylindrical pressure type sterilizers. **American Sterilizer Co., Dept. MH, Erie, Pa. (Key No. 318)**

Sanitizing Products

Wyandotte Spartec and Wyandotte Tri-Bac are two new sanitizing compounds containing quaternary ammonium germicides which have recently been added to bring the line up to five compounds of this type.

Spartec is a liquid containing 10 per cent of methyl dodecyl benzyl trimethyl ammonium chloride ordinarily used at the rate of 1 fluid ounce to 4 gallons of water to provide a clear, odorless, colorless, non-corrosive solution for cleaning glassware. It can be used at any temperature as boiling does not lower its potency and it is designed to be used as a general sanitizing agent following thorough cleansing.

Tri-Bac is a free-flowing white powder with triple action—detergent, germicidal and deodorizing. It is non-irritating and fast acting but is not recommended for

use on heavy soil, stain or grease. **Wyandotte Chemicals Corp., Dept. MH, Wyandotte, Mich. (Key No. 319)**

Metal Folding Chair

The new Royal metal folding chair is carefully constructed for strength and attractive appearance. The telescoping back legs simplify the mechanism. The frame is constructed of $\frac{3}{4}$ inch diameter steel tubing with all cross bracing completely welded. All joints and connections are assembled for strength and the solid rubber feet protrude from inside the tubing providing a large bearing and wearing surface on the floor. The chair is available in four models: the all-metal chair with one piece steel seat, the scroll shaped steel seat with tempered Masonite panel, the padded, upholstered seat, and the de luxe Royalchrome with Flex-spring seat and padded back. **Royal Metal Mfg. Co., Dept. MH, 175 N. Michigan, Chicago 1. (Key No. 320)**

Decimal Tabulator

The new Remington Electric Typewriter with Ten-Key Decimal Tabulator is designed to speed up typing of statistical, billing, accounting and other columnar material. The tabulator mechanism has been built into the Remington Electric Speed Slope keyboard for maximum convenience and accessibility. All machines are furnished with the new Remington Rand All Nylon ribbon developed especially for electric typewriters, and the machines are available in all carriage widths up to 27 inches. **Remington Rand Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 321)**

Sound System

RCA has announced a newly engineered radio and sound distribution system which is designed primarily to afford entertainment and relaxation for patients in hospitals of 50 to 500 beds. Consisting of an FM and AM antenna, a basic 4 channel AM-FM central station installation and special hospital reproducer equipment, the system can be used with pillow speakers, individual monoset earphone equipment or wall speakers. Patients may have a choice of program

and a special time switch and clock automatically control the daily program schedule. No operating personnel is required for the system.

Patients may be charged a nominal daily fee for this radio service, in which case the system will pay for itself in a relatively short time after which it will be a source of income for the hospital. Loud-speakers may be installed to provide entertainment in recreation rooms, dining rooms, solariums and other areas in the hospital or nurses' home. **RCA Victor Div., Radio Corporation of America, Dept. MH, Camden, N. J. (Key No. 322)**

Combination Scrubber-Vac

The new No. 418P Combination Scrubber-Vac recently introduced by Finnell System has the advantage, highly desirable for use in hospitals, of exceedingly quiet operation. The self-propelled unit, with an 18 inch brush ring, is designed for use in small-area buildings, with floor areas ranging from 2000 to 15,000 square feet.

The new machine handles both wet and dry work and is the result of many years of experience in building combination floor machines. The No. 418P applies the cleanser, scrubs, rinses and picks up in a single operation, thus producing clean floors in a minimum of time with



little effort. It has all of the refinements and careful construction features of all Finnell equipment. **Finnell System, Inc., Dept. MH, Elkhart, Ind. (Key No. 323)**

China Design



The new Winthrop shape in china service has been designed to offer a more home-like atmosphere in institutional china. The new line is outstanding because of its attractive edge design which differs from the conventional smooth edge design. Also new is the "bridge-type" body construction which combines light appearance with exceptional strength. It is highly resistant to mechanical shock, heat and pressure.

Three cup designs are available in the new Winthrop shape, developed by Syracuse China research laboratories, and the patterns include central floral designs with solid color borders as well as all-over flower and leaf motifs. **Onondaga Pottery Co., Dept. MH, Syracuse 4, N. Y. (Key No. 324)**

Aerosol Unit

A new fully automatic aerosol interrupted demand unit has recently been introduced for convenience and economy in the broncho-pulmonary administration of antibiotics. A feature of the unit is an interrupted demand device which automatically allows the oxygen to nebulize the aerosol antibiotic during the early portion of the patient's inhalation only. A special control automatically stops the flow of oxygen and the nebulization of the aerosol during the latter part of the inhalation phase and during the exhalation phase of the breathing cycle. The unit may be equipped with a new type of oronasal mask, small or standard size. **Ohio Chemical & Surgical Equipment Co., Dept. MH, 1400 E. Washington St., Madison 10, Wis. (Key No. 325)**

Room Air Conditioner

The new Fresh'nd-Aire Model 600 room air conditioner and humidifier is also designed to serve as a room deodorizer. Air is drawn in through a filter over which a continuous water-falling action takes place, thus washing the air, filtering out smoke, dust and dirt and removing odors before it is circulated back into the room. Air is blown out the top of the

unit by a circulating fan. The operation is continuous and the unit handles approximately 13,000 cubic feet of air per hour. **Fresh'nd-Aire Co., Dept. MH, 221 N. La Salle, Chicago 1. (Key No. 326)**

Dumb Waiter

A new type, self-contained, complete Under-Counter Dumb Waiter unit has recently been introduced for use where scant headroom conditions indicate use of a compactly designed, easy-to-install unit. The new Sedgwick model is of all-metal construction, thus fireproof, and is designed for various capacities ranging up to 300 pounds. The unit usually employs a car approximately 24 inches wide, 20 inches deep and 26 inches high, fitted with a removable shelf. **Sedgwick Machine Works, Dept. MH, 90 Eighth Ave., New York 11. (Key No. 327)**

Bath Thermometer

The new No. 5604 Taylor All-Purpose Bath Thermometer was designed by Walter Dorwin Teague, industrial designer, for efficient operation and handling. It is intended to agitate and then accurately indicate water temperatures, not only for baths but for hot water bottles, enemas, douches, foot soaks and throat irrigations. The combination one piece green plastic scale and nonslip handle are chip and rustproof and will not soak up water.

The open scale has large white figures and graduations applied with a special silk screen paste which etches and then turns very hard and durable, ensuring permanent legibility. The bright red filled tube is recessed into the sturdy plastic case to minimize the possibility of breakage. The thermometer can be easily washed with detergent without causing deterioration in utility or appearance. **Taylor Instrument Companies, Dept. MH, 95 Ames St., Rochester 1, N. Y. (Key No. 328)**

50 Ounce Soup Service

Cream of Chicken Soup is now available in the 50 ounce institutional sized cans offered in the Campbell line. This new soup is added to the line of Campbell soups now available in this size which include Bean with Bacon, Beef Noodle, Chicken with Rice, Chicken Noodle, Clam Chowder, Consomme, Cream of Mushroom, Green Pea, Tomato, Vegetable and Vegetable-Beef. **Campbell Soup Co., Restaurant Div., Dept. MH, Camden, N. J. (Key No. 329)**

Redesigned Croupette

The Croupette humidity and oxygen tent has been completely redesigned. The new model has an ice chamber for cooling in warm weather and a method of air circulation which permits high oxygen concentrations. The unit produces a relative humidity of 90 to 100 per cent and maintains oxygen concentrations of 45 to 65 per cent at a flow of 5 to 8 liters per minute.

In addition to its use for infants, the new unit can serve as a head tent for adults, as a practical substitute for a steam room and as an oxygen tent when high humidities are indicated. **Air-Shields, Inc., Dept. MH, Hatboro, Pa. (Key No. 330)**

Gravity Feed Slicer

The new Globe Model 150 gravity slicing machine is streamlined, finished in hard-baked enamel with heavy chromium plating on all metal parts. All parts coming in contact with food are either porcelain or anodized aluminum. Features of the new model include a built-in angle slicer; a new safety switch; a new high-angle, rim-touch blade, and a new broad-side gravity feed chute. **The Globe Slicing Machine Co., Dept. MH, Stamford, Conn. (Key No. 331)**

Dictating System

The new high-fidelity, sound-on-wire Sonograph is described as a complete dictating system, with one unit for both dictation and transcribing, no processing or replacement of discs or cylinders and extremely low operating cost. The machine starts, stops and reverses by slight toe pressure, has a synchronized word meter which counts and indexes each word and a push-button microphone. Each spool of stainless steel wire provides an hour of recording and the wire is reusable indefinitely. An earphone plug-in adds convenience for transcribing.

Known as the Sonograph, the machine is compact, durable, easily portable, as it weighs less than 21 pounds, and has a



low cost price. **Pentron Corp., Dept. MH, 607 W. Division St., Chicago 10. (Key No. 332)**

Floor Machine

The new Model 12W floor machine is designed for use in small, congested areas around beds, lockers and other equipment. The new adjustable handle is so designed that it can be locked in position or regulated to operate in a flexible position allowing free movement anywhere within an 80 degree arc for reaching under fixtures and into hard-to-reach areas. The handle can be lowered to horizontal position. All adjustments are made by foot lever.

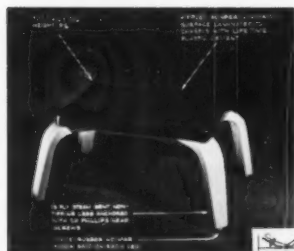
The machine is designed to scrub, wax and polish with maximum power and minimum noise. A large rubber bumper protects furniture and machine. The brush spread is 12½ inches and the heavy duty ¼ h.p. motor has a cover which permits easy access to motor and mechanism. S. C. Lawlor Co., Dept. MH, 126 N. Aberdeen St., Chicago 7. (Key No. 333)

Whirl-Blade Mower

The new Whirlaway 20 mower is powered by a vertical shaft engine which provides direct application of its power to the horizontal blade. This allows for elimination of a clutch and belt-drive, thus simplifying the design. Three pneumatic tired wheels, two rear and one front, all mounted on ball bearings, are so placed as to compensate for any unevenness of terrain, thus facilitating cutting grass around trees. The mower is easily propelled and the height is adjustable from 1½ to 3 inches. The Moto-Mower Co., Dept. MH, 4800 Woodward Ave., Detroit 1, Mich. (Key No. 334)

Foot Stool

A streamlined foot stool in modern design, constructed to prevent tipping, is being offered as the "Streamliner" Foot Stool. The 13 ply steam bent non-tipping legs are anchored with 20 Phillips head screws. The 14¼ by 10¼ inch rippled rubber non-skid top is laminated to the chassis with plastic cement. Each leg has a non-marring white rubber floor



grip. Hospital Furniture, Inc., Dept. MH, 936 N. Michigan Ave., Chicago 11. (Key No. 335)

Portable Refrigerator

The Junior Series of "Cargo Reefers" provides portable refrigeration storage facilities where built-in installations are impossible or inadequate. Of completely welded steel, the reefers are available in 150 and 200 cubic foot sizes and are equipped with self-contained gasoline and electric driven refrigerating units. They are skid-mounted with lifting and towing eyes and can be easily moved if desired.

The units have been designed to permit operation either at zero temperature for storage of frozen foods or at medium temperatures for general refrigerated storage. A separate compartment at the rear of the unit houses the refrigerating system. Reco Products Div., Refrigeration Engineering Corp., Dept. MH, 2020 Naudain St., Philadelphia 46, Pa. (Key No. 336)

Infant Formula Controls



Designed especially for use in terminal treatment of infant formula, the new Inform Control indicates when the desired exposure of 10 minutes at 230 degrees F. has been obtained. An Inform Control suitable for use at a lower exposure of 25 minutes at 212 degrees F. will soon be also available.

Consisting of a pellet suspended in a glass tube, the Inform Control was designed for use in the autoclave treatment of milk. The control is dropped into a test bottle which is placed centrally in the formula load. The pellet indicates proper exposure conditions by melting and running down the tube only if time and temperature requirements are satisfied. Smith & Underwood (Diack Controls), 1847 N. Main St., Royal Oak, Mich. (Key No. 337)

Odorless Paint

Interior hospital renovations can now be done with a new odorless paint recently developed. Known as Keystone One Coat Flat Oil Paint, the product is a finish for use on walls, ceilings and woodwork. The specifically formulated process which makes the paint odorless is the result of 15 years of laboratory experimentation. Rooms can be occupied immediately after painting with the new product without fear of paint odor. Keystone Paint & Varnish Co., Dept. MH, 71 Otsego St., Brooklyn 31, N. Y. (Key No. 338)

Pediatric Department Beds



Safety, service and convenience are built into the new Hill-Rom youth beds and cribs. The safety catch to prevent the occupant from lowering the sides is conveniently placed just above the casters so that it can be operated by the nurse by merely stepping on the pedal. The rods in the sides of the bed are of tubular metal with a baked-on finish which is washable and free of lead. They are closely spaced to prevent the possibility of a child putting his head through the openings. The ends are of wood with the chipproof, washable Hill-Rom hospital furniture finish. Both sides of the bed are adjustable as to height.

The youth bed is equipped with the Hill-Rom heavy duty gatch spring, the National fabric bottom is cadmium plated and rustproof with no sharp points to tear bedding and the 3 point wedge corner lock ensures a permanently rigid bed. All cribs are of the same quality and differ only in size and in the type of spring. The No. 2504 youth's bed and the No. 2505 crib are equipped with gatch springs, the No. 2506 and No. 2507 cribs have the Adjus-Tilt spring and the No. 2508 crib the flat fabric spring. The units range in size from 26 by 72 inches down to 26 by 42 inches. Hill-Rom Co., Inc., Dept. MH, Batesville, Ind. (Key No. 339)

Steel Frame Furniture

A newly developed steel frame davenport and chair have been introduced especially for institutional use. The furniture was designed and engineered by the National Furniture Manufacturing Company in cooperation with the U. S. Rubber Company and the Stran-Steel division of the Great Lakes Steel Corporation. The furniture has a steel frame, foam rubber cushioning and heavy gauge covering material, thus making it practical for use in lobby, reception room, solarium and other areas where it would have hard usage. National Furniture Mfg. Co., Dept. MH, Evansville, Ind. (Key No. 340)

Automatic Door-Opener



Automatic door opening, which permits nurses and surgeons to pass through a door without touching it with their hands, and saves setting down trays or propping or kicking doors open when attendants wish to enter when both hands are occupied, is now offered by the Astra Automatic Door Control. Installed without remodeling of doors, walls or floors, the unit electrically initiates door opening when anyone walks on the floor area on either side of the door. The floor plate which governs the contact area is only 3/16 of an inch thick and its low-angle rising edges makes a safe, smooth approach for foot traffic, dressing carriages, wheel chairs and other equipment.

Both opening and closing of doors are air-operated and hydraulically controlled. Minimum maintenance is required because there are no gears or motor. Electricity is furnished from an ordinary 110 volt wall outlet and air power is supplied by the building's regular air pressure system. If the latter is not available, a small compressor will supply the air. In case of power failure the doors may be manually operated. The unit is said to save time and effort and to be reasonable in cost. **Astra Engineering Co., Dept. MH, 933 S. Fair Oaks, Pasadena, Calif. (Key No. 341)**

Dispensers

A new line of dispensers for paper towels and toilet paper has recently been announced. The single-fold junior paper towel dispensers are available in both chrome and baked white enamel finishes and are built for long use. The curved doors are equipped with full-length hinges for long wear and lock and key eliminate tampering. The paper is automatically fed by gravity through the bottom slot. The double-fold general purpose towel dispensers dispense double-fold paper towels of most makes and

have flat front doors with rounded corners to eliminate the possibility of catching and tearing clothes.

The new line of toilet paper dispensers is designed to dispense either single or double-fold toilet paper. They have stainless steel tops with white enamel bodies and the full sized front door is held in place by a lock. A slot in the lower front indicates when refilling is required. **The Bennett Mfg. Co., Dept. MH, Alden, N.Y. (Key No. 342)**

Multilith Model 75

The new Multigraph duplicator, the Multilith Model 75, has several improvements. Operation has been simplified, including immediate run even after periods of inactivity. Ink and water are mixed outside, thus ensuring automatic balance and making daily clean-up unnecessary. The new Simflo Control mechanically controls many steps formerly done manually and the compact, new Vacuum Feeder permits uninterrupted machine operation without stopping to load blank paper or to remove finished copies.

Copies can be reproduced from all types of Multilith Duplicating Masters with the new Model 75. Masters are prepared with pens, pencils, typewriters or other utensils for reproduction of business forms as well as all types of general duplicating. **Addressograph-Multigraph Corp., Dept. MH, 1200 Babbitt Rd., Cleveland 17, Ohio. (Key No. 343)**

Prefinished Wood and Marble Panels

Marlite plastic-finished wall and ceiling panels are now available in a new line of prefinished wood and marble patterns. The grain and finish of selected fine woods are faithfully reproduced in 5 of the new Marlite patterns and 5 others are authentic reproductions of imported marbles. Wood pattern panels are available in sizes 48 by 72 and 48 by 96 inches, with the grain running in the direction of the second dimension, in Quartered Prima Vera (Harewood Gray or Natural), Plain Walnut, Rift Oak and Striped Mahogany finishes.

The large, convenient marble panel patterns come in 32 by 48 and 96 by 48 inch sizes in Rose de Brignoles, Jaune Benou, Black and Gold, Skyros and Verdo Antique. The hard, durable, permanent plastic finish seals in all the beauty and color while sealing out dirt, grease and moisture. The panels are easily cleaned by wiping with a damp cloth. They are easily applied over old or new walls and can be installed with ordinary carpenters' tools. **Marsh Wall Products, Inc., Dept. MH, Dover, Ohio. (Key No. 344)**

Portable Vacuum Cleaner

The Tornado Portable Vacuum Cleaner is designed to be slung over the shoulder, thus leaving both hands free to guide the attachment. It has a strong, steady suction which is especially suited for quick, thorough cleaning in confined places, in storage shelves, under machinery and work benches, on overhead pipes, in stairways and in similar hard to reach areas. It is available in 4 sizes and has a universal motor mounted on permanently sealed bearings. The cast aluminum motor housing is of a new design which eliminates excessive operating heat and the entire mechanism is enclosed in a sturdy, light weight, streamlined aluminum fan housing. The cleaner is supplied with 20 feet of special heavy duty cable and operates from any convenient electric light outlet. **Breuer Electric Mfg. Co., Dept. MH, 5100 Ravenswood Ave., Chicago 40. (Key No. 345)**

Nightingale Lamp

Designed with the advice of hospital personnel and patients, the new Nightingale Hospital Lamp is attached to the bed frame, thus saving floor space, and can be turned in any direction due to the universal base joint. Its flexibility makes it available for the patient, for doctors and nurses for examination or treatment, for visitors or merely as a general light.

The lamp is shielded for comfortable use and the manufacturer states that it is approved by and listed with the Underwriters' Laboratories. The lamp is sturdily built for long service yet is designed for quick, easy repairs. It maintains any position and is easily and quickly attached to or removed from any standard hospital bed frame. The mounting mechanism is so designed that neither mattress nor bedrail interferes



with adjustment of the lamp. **Adjustable Fixture Co., Dept. MH, 104 Mason St., Milwaukee 2, Wis. (Key No. 346)**

Acoustical Material

Three new acoustical products have recently been introduced. Travacoustic, a mineral tile, is fabricated from Rock Wool and precut into uniform sizes and standard thicknesses. It is designed to provide a high degree of sound absorption and light reflection, is incombustible and has a white coating which can be cleaned or repainted without loss of acoustical efficiency. Thermacoustic, developed from mineral wool, is a fireproof material especially designed to be sprayed on ceilings and arches. It may be applied in any desired thickness and is effective for both noise reduction and thermal insulation and can be painted.

The third new product is Acoustifibre, an improved wood-fiber tile with perforations to deaden noise. It also can be repainted many times without decreasing its acoustical value. National Gypsum Co., Dept. MH, Buffalo 2, N.Y. (Key No. 347)

Grind-a-Leaf Mower

The Mow-Master Grind-a-Leaf is an attachment for the Mow-Master which collects and grinds leaves as the lawn is being mowed, and scatters them evenly over the grass as a fertilizer. Thus it performs three operations in one: mowing, clearing leaves and scattering fertilizer.

The Grind-a-Leaf is of light weight, aluminum alloy construction, except for wearing parts and shroud, and is powered by a Power-Pak utility motor. It is ruggedly constructed for long wear, is easily maneuvered, has shielded cutter blade, automatic governor, manually operated throttle control on handle bar, adjustable handle and is easily started. Propulsion Engine Corp., Dept. MH, 7th and White Eagle Rd., Kansas City 15, Kans. (Key No. 348)

Ice Maker



The Rapid Freeze Ice Cube Maker is a low cost unit capable of producing 2300 cubes or 250 pounds of ice per day. It features simple, plug-in operation with no plumbing installations necessary. The

large, easy-opening storage bin holds the continuous supply of ice cubes. Each freezing makes 384 cubes or 40 pounds of ice at a minimum of cost.

The unit is compact and easily moved if desired. It is 24 inches deep, 40 1/4 inches high and 38 inches wide and is constructed of all-welded steel with silver hammertone finish. It is available with or without a condensing unit and is designed to accommodate any standard 1/2 h.p. hermetic or open type unit. It operates on alternating current and is equipped with expansion valve, temperature control, heat exchanger and drier. The Rapid Freeze is manufactured by the Brewer-Tichener Corporation, Cortland, N. Y., and is being distributed by Refrigerated Sales Corp., Dept. MH, 19 W. 44th St., New York 18. (Key No. 349)

Thermostatic Water Controller

Model "BAM" is a new thermostatic water controller for group showers and purposes requiring multiple outlets. It controls thermostatically the mixing of hot and cold water to deliver it at the desired constant temperature. Failure of the cold water supply causes the hot water seat to close and prevents scalding, and failure of the hot water supply causes the cold seat to close.

Constructed of brass, copper and bronze, the unit has bronze built-in strainers and check valves which are easily removed. The new controller is carefully assembled and set to deliver water at any temperature between cold and 110 degrees F. A higher or lower maximum temperature can be furnished if desired. Adjustments within the range allowed are easily made and the controller can be locked at any desired setting. Lawler Automatic Controls, Inc., Dept. MH, 453 N. MacQuisten Pkwy., Mount Vernon, N. Y. (Key No. 350)

Addressing Machine

Addressing envelopes, pamphlets, public relations releases and other material can be simplified by use of the new Model A-2 Weber Addressing Machine. The mailing list is typed on a roll of special paper, inserted in the machine and can be used over and over again, as many as 100 times, to produce facsimile typewritten addresses. Corrections or changes in the list are easily handled and the machine is simple to operate. The Weber Ad-roll, which holds up to 500 names and addresses, takes up small space for storing when not in use. Anyone can learn to operate the machine and can address from 2000 to 2500 pieces per hour with a little experience. Weber Addressing Machine Co., Dept. MH, Mount Prospect, Ill. (Key No. 351)

Maintenance Trestle



Several improvements have recently been made in the Bil-Jax Maintenance Trestle. Designed to simplify overhead maintenance jobs, wall washing, store room work, painting and construction work, the trestle now has rubber tired casters which can be locked in position, guard rails, window tie-ins and brace lugs which permit grouping of trestles to provide multiple work platforms. The trestle is also available with ordinary casters and has an adjustable stem which permits use over stairways and on other non-level surfaces.

The basic trestle consists of two 5 foot base sections, two regular heads which are reversible and one 8 foot trussed overhead ladder. The unit stands 7 feet high and its parts can be arranged to supply a platform of any desired height from 1 foot to 8 feet. Additional height can be obtained by adding extra ladder sections in 3 or 6 foot lengths. Catwalks may be spaced to provide 1 to 3 or more working levels. Side brackets, trussed plank rest, combination reversible head and low base for use in narrow passageways are accessories which extend the usefulness. Bil-Jax, Inc., Dept. MH, Archbold, Ohio. (Key No. 352)

Nylon Paint Brushes

A series of 11 new 100 per cent nylon paint brushes has been added to the present line of pure bristle paint brushes manufactured by the Fuller Brush Company. The new nylon filaments are said not to split, fray or become brittle, to be resistant to most chemicals and to be unaffected by age or weather, rodents, insects and fungi. They can be used with all types of oil and water paints, synthetics, lacquers, kalsomines and enamels and have long life. A special sanding process has softened the tips of the brushes and improved capillary attraction. The line includes 8 sizes of wall brushes, 2 stucco brushes and 1 kalsomine brush. The Fuller Brush Co., Dept. MH, Hartford 2, Conn. (Key No. 353)

Plastic Window Shades

Long wear and reduced maintenance are features of the new Plastishades recently announced. Made with a new Vinylite plastic film specifically formulated for the window shade market, Plastishades have successfully withstood rigorous testing and severe laboratory examination by the United States Testing Company. They can be easily and thoroughly cleaned by using soap and a damp cloth or sponge. The material is unaffected by moisture, mildew or insects, will not tear or puncture in normal use and does not support flame. It is resistant to fading, cracking, shrinking and staining and does not ravel.

Plastishades are available in ivory, white, green and tan and are made in 36, 42 and 48 inch widths and 6 and 7 foot lengths. Other sizes can be made to order up to 48 inches wide and 9 feet in length. **Charles W. Breneman Co., Dept. MH, 2045 Reading Rd., Cincinnati 2, Ohio (Key No. 354)**

Slide Projector

Intended primarily for the educational and training fields, the new Spencer MC Delineascope, finished in gray and maroon, has been developed for the projection of color slides. It handles slidefilms, 2 by 2 inch slides or both slidefilms and slides. The operator can switch instantly from one medium to the other.

The new model is designed to accommodate a wide range of projection conditions. Operating with an inexpensive, cool 300 watt bulb, it produces improved screen brilliance and color contrast to the edge of the slide. Slides are easily inserted and are guided by slideways. The projector has a framing lever that centers the picture on the screen and a rotatable front enabling slidefilms to be rotated to any desired position. The efficient cooling system eliminates the possibility of contact burns. **American Optical Co., Dept. MH, Buffalo 15, N. Y. (Key No. 355)**

Instru-Mount

The Eberbach Instru-Mount is designed to eliminate vibration in laboratory instruments. It is a vibration damping, non-magnetic base which protects delicate mechanical or other instruments from vibrations with frequencies as low as 10 cycles per second. Made entirely of non-ferrous, non-magnetic materials, the Instru-Mount cannot influence electrical instruments. It weighs 50 pounds, has a platform 2½ inches thick and measures 22 by 12 inches. **Eberbach & Son Co., Dept. MH, Ann Arbor, Mich. (Key No. 356)**

Pharmaceuticals

Depo-Heparin Sodium

Depo-Heparin Sodium and Depo-Heparin Sodium with Vasoconstrictors are repository forms of the normal tissue anticoagulant, heparin. Their use is indicated in thrombophlebitis and phlebotrombosis, in arterial occlusion, as prophylaxis against thrombosis and for prevention and treatment of postoperative venous thrombosis. The products are sterile preparations of heparin sodium dissolved in an aqueous vehicle containing gelatin and dextrose which slow the absorption. The presence of vasoconstrictors further extends the prolonging effect. The product is supplied in 1 cc. cartridges with disposable syringe for injection in the deep subcutaneous or superficial intramuscular tissue. **The Upjohn Company, Dept. MH, Kalamazoo 99, Mich. (Key No. 357)**

Sulfamylon-Streptomycin

Sulfamylon-streptomycin is now available for the reduction of surgical infections. Administration of the two drugs in combination has proved effective in reducing the percentage of infection in wounds and in increasing the healing process. Sulfamylon-streptomycin is marketed in a combination package that includes a vial of 100 cc. of 5 per cent Sulfamylon and another vial of 20,000 units of streptomycin. **Winthrop-Stearns Inc., Dept. MH, 170 Varick St., New York 13. (Key No. 358)**

Vasoxyl

Vasoxyl brand Methoxamine Hydrochloride Injection is described as a potent pressor drug with prolonged action designed to maintain or restore blood pressure during operative procedures. It is available as the hydrochloride in sterile aqueous solution for parenteral use, issued in boxes of 12 and 100, and is said not to produce cardiac arrhythmia even when used with cyclopropane anesthesia and not to produce cerebral stimulation. **Burroughs Wellcome & Co. (U.S.A.) Inc., Dept. MH, Tuckahoe 7, N. Y. (Key No. 359)**

Corenil

Corenil is designed for the symptomatic relief of coryza and allergic rhinitis. It contains a cerebral stimulant to compensate for the sedative effect frequently associated with antihistamines while the extract belladonna has been included to provide depression of nasal secretions. It is available in tablet form in bottles of 100 and 1000. **McNeil Laboratories, Inc., Dept. MH, Philadelphia 32, Pa. (Key No. 360)**

Eticylol Linguets

Eticylol Linguets are a derivative of the naturally occurring estrogen, alpha estradiol, and are supplied in tablet form, 5 mg. per tablet, for administration in mammary carcinoma and carcinoma of the prostate. It is prepared to permit absorption directly into the systemic circulation through the oral mucosa. The Linguets are supplied in bottles of 30 and 100. **Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N. J. (Key No. 361)**

Sulestrex Piperazine

Sulestrex Piperazine is a synthetic, stable, water-soluble form of estrone for oral administration. It provides conjugated natural estrone in a purified tablet form that is odorless, practically tasteless and leaves no unpleasant aftertaste. Designed for administration in the menopausal syndrome, the 0.75 mg. tablets are supplied in bottles of 100 and the 1.5 mg. tablets in bottles of 25 and 100. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 362)**

Penicillin Products

Penicillin Confets Schenley are designed primarily for use with children for the oral treatment of infections caused by penicillin-sensitive organisms. Each tablet contains 50,000 units of buffered crystalline penicillin G potassium in a pleasantly flavored sugar base. They are supplied in glass tubes of 12, 3 each of white, pink, green and yellow.

Soluble Crystalline Penicillin Tablets Schenley, also adaptable for pediatric use, are indicated for general oral penicillin therapy where large tablets are inconvenient, for penicillin aerosol inhalation and for sublingual administration as well. Each tablet contains 100,000 units of crystalline penicillin G potassium without binders, buffers or excipients. They are supplied in packages of 24 and 100 foil-wrapped tablets. **Schenley Laboratories, Inc., Dept. MH, 350 Fifth Ave., New York 1. (Key No. 363)**

A-C-K Tablets

A-C-K Tablets are described as an improved form of salicylate therapy designed for the treatment of rheumatic fever, arthritis, tuberculosis, dysmenorrhea, intra-ocular inflammation and otolaryngology. Each tablet contains 5 gr. acetylsalicylic acid, 1/200 gr. menadione and ½ gr. ascorbic acid. Menadione and ascorbic acid have been added to help maintain prothrombin at a normal level without altering the salicylic acid concentration. A-C-K Tablets are supplied in bottles of 100 and 1000. **The G. F. Harvey Co., Dept. MH, Saratoga Springs, N. Y. (Key No. 364)**

Glucurone-C.S.C.

Glucurone-C.S.C. is the result of cooperation between the research division of Corn Products Refining Company and clinical investigations carried out under the direction of C.S.C. Pharmaceuticals. The product is provided in tablet form for the oral treatment of arthritis and other joint afflictions. Investigators state that it has been found to produce no deleterious effects upon the liver or kidneys, or the circulatory or nervous systems. It exerts little if any analgesic action but is said to attack the factors responsible for the arthritic process. It is supplied as Glucurone Tablets-C.S.C., each containing 0.5 Gm., in bottles of 75 tablets. C.S.C. Pharmaceuticals, Div. of Commercial Solvents Corp., Dept. MH, 17 E. 42nd St., New York 17. (Key No. 365)

Gantrisin 'Roche'

Gantrisin 'Roche' is described as a sulfonamide especially useful in urinary tract infections, which has comparatively high solubility even in neutral and slightly acid body fluids. It is rapidly absorbed upon oral administration and is readily excreted with no evidence of accumulation. Gantrisin is available in tablets, 0.5 Gm. each, in packages of 100, 500 and 1000; as a syrup, 0.5 Gm. per 5 cc. in 4 ounce and 1 pint bottles and in 10 cc. ampules, each containing 4.0 Gm. in packages of 1 and 6. Hoffmann-La Roche Inc., Dept. MH, Nutley 10, N. J. (Key No. 366)

Panparmit

Panparmit, (R) is a new synthetic drug for reduction of rigidity and tremor in Parkinson's Disease. The essential action of this new product appears to be the blockage of proprioceptive impulses arising in muscles and joints. It is supplied as sugar coated tablets of 12.5 mg. and 50 mg. and is said to avoid the disagreeable side effects of conventional therapy causing dry mouth and disturbances of vision. Geigy Company, Inc., Dept. MH, 89 Barclay St., New York 7, (Key No. 367)

Anti-Rh Factor Typing Sera

Two forms of Anti-Rh Factor Typing Sera are now available: Anti-Rh₀ (Anti-D) 85 per cent Serum and Anti-Rh₀ (Anti-C plus D) 87 per cent Serum. Both forms are standardized and may be used with oxalated blood, fresh blood or clotted blood as well as for slide testing. They are supplied in 5 cc. vials and may be used with the tube test as well. Lederle Laboratories Div., American Cyanamid Co., Dept. MH, Pearl River, N. Y. (Key No. 368)

Product Literature

• Designed to be a valuable help in solving washing, cleaning and other maintenance problems, the new 1950 **Handy Soap Buying Guide** published by Colgate-Palmolive-Peet Co., 105 Hudson St., Jersey City 2, N. J., presents a complete résumé of the company's line of soaps, synthetic detergents, cleansers, washing powders, bar and dispenser soaps, including product descriptions, packs, sizes and units available and other helpful information. (Key No. 369)

• Described by the company as "One Complete Source for the Hospital Buyer," the new catalog of A. S. Aloe Co., 1831 Olive St., St. Louis 3, Mo., is an impressive and attractive 810 page, board-bound book containing descriptive information and illustrations of the thousands of equipment and supply items available from the firm. Some of the items are shown in color, floor plans are suggested for the placement of Moduline cabinets and casework, prices are included on all items and the catalog is fully indexed. (Key No. 370)

• "Behind the Window" is a full length documentary film produced by Louis de Rochemont for E. R. Squibb & Sons, 745 Fifth Ave., New York 22. Designed primarily to document the services rendered retail pharmacy by the manufacturer, the film has general interest and pictures both the pharmacy and its place in the community and the research, product development and control maintained by the manufacturer. (Key No. 371)

• "Life-Long Products for Centralized Nurseries and Rooming-In Arrangements," as developed by Hard Mfg. Co., 117 Tonawanda St., Buffalo 7, N. Y., are discussed in a new folder recently received. Data on the full line of products are included together with detailed information on the Dual-Purpose Bassinet, Model 111. (Key No. 372)

• Detailed information on **The Vogt Class VL Bent Tube Boiler** is given in an 18 page catalog recently released by Henry Vogt Machine Co., 10th & Ormsby Sts., Louisville 10, Ky. The Class VL Boiler is designed for adaptation to limited space conditions, when necessary, in institutions having diverse steam requirements. (Key No. 373)

• **Bulletin No. 639D on Dunham Baseboard Radiation** is an attractive 16 page booklet printed in 2 colors and issued by C. A. Dunham Co., 400 W. Madison St., Chicago 6. It contains complete ratings and all engineering data necessary to determine radiation sizes and piping design as well as photographs of actual installations of this type of radiation. (Key No. 374)

• "The Needle Suture Selector" is designed to simplify the purchase of sutures. A circular, glossy cardboard wheel, 9 inches in diameter, printed in gray, white and blue, the Selector has a movable circular "bull's-eye" in the center containing a cut-out strip. When turned to the desired type of suture, corresponding figures printed on the concealed area of the card appear in the cut-out section, indicating that the suture is available in certain different sizes. Code numbers are immediately shown for ordering, thus simplifying the procedure. The reverse side gives codings for needle sutures with cutting point needles. Designed to overcome the unavoidable complexity of the standard printed catalog, the Selector saves time and effort and is available from Ethicon Suture Laboratories, Inc., New Brunswick, N. J. (Key No. 375)

• A 6 page folder on the **Cannon Locking Pushbutton** and related equipment used in nurses' call bedside stations has recently been released by Cannon Electric Development Co., 3209 Humboldt St., Los Angeles 31, Calif. This new and revised **Bulletin No. HLS-2** contains a typical floor wiring and schematic wiring diagram covering 3 pages, in blueprint-style, together with photographs of the various units and dimensional sketches of the standard wall receptacle and the push button with cord and plug. (Key No. 376)

• **Bulletin 5400K-1, "The New Fairbanks-Morse Bladeless Sewage and Trash Pump,"** issued by Fairbanks, Morse & Co., 600 S. Michigan Ave., Chicago 5, gives full information on a new type of pump recently developed by the company for handling trash and sewage. (Key No. 377)

• An illustrated folder, "Goodall Presents Extensive Line Additions," has been issued by Goodall Fabrics, Inc., 525 Madison Ave., New York 22, to show the new 1950 line of fabrics recently brought out. The line consists of 21 hand printed designs in 125 color combinations and 9 new upholstery weaves with 129 colorations. The patterns are available on 4 basic cloths: Goodall's new casement fabric; a rayon and mohair cloth; the linen-like Aristo cloth, and Angora Satin. The folder illustrates 23 new numbers. (Key No. 378)

• "How to Select an Acoustical Material" is the title of a new 16 page booklet published by Armstrong Cork Co., Lancaster, Pa., to acquaint executives and architects having problems of sound and its control with the use of the proper acoustical material. It is written in non-technical language and discusses both acoustical correction and noise-quelling. An interesting feature is the section on "Installation Methods." (Key No. 379)

• **Catalog H50, Kohler Plumbing Fixtures**, has been published by Kohler Co., Kohler, Wis., especially for hospitals, medical and dental clinics, sanitariums and allied institutions. It is attractively laid out and printed, fully indexed, and contains illustrations and descriptions of hospital bath tubs and therapy baths, autopsy tables, surgeons' lavatories, service and laboratory sinks, closets, urinals, bed pan and urinal washers and sterilizers, plumbing fixtures and fittings for patients' bathrooms and washrooms and Kohler plants for stand-by power. (Key No. 380)

• Problems involved in the flexible division of interior space are discussed and solutions offered in the **Mills Movable Metal Walls Catalog No. 50** recently issued by The Mills Company, 975 Wayside Rd., Cleveland 10, Ohio. The book presents a clear exposition of the many advantages of movable walls, their structural stability, architectural design, adaptability to changing space needs, soundproofing, low maintenance requirements and other points. The catalog is fully illustrated with photographs, diagrammatic drawings and charts and contains specification data. (Key No. 381)

• Special operating hardware is featured in the new **Catalog K396, Eighth Edition**, recently published by P. & F. Corbin Division, the American Hardware Corp., New Britain, Conn. The 50 page catalog contains complete information covering a variety of P. & F. Corbin developed products with all data necessary to meet specifications. (Key No. 382)

• A 24 page booklet on **"Tygon Flexible Plastic Tubing"** and its various properties and uses has recently been issued by U. S. Stoneware, Akron 9, Ohio. Complete information on the product is given in booklet T-77. (Key No. 383)

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it. If you read the hospital copy or the administrator's copy of THE MODERN HOSPITAL or for any other reason do not wish to clip the magazine itself, upon request we shall be glad to send you regularly a reprint of this department containing the coupon.

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- ☐ 377 Bulletin 5400K-I
- ☐ 378 Goodall Fabric Line
- ☐ 379 "Select Acoustical Material"
- ☐ 380 Catalog H50
- ☐ 381 Catalog No. 50
- ☐ 382 Catalog K396
- ☐ 383 "Tygon Flexible Plastic Tubing"
- ☐ 384 Books
- ☐ 385 Books

Book Announcements

W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. Edited by Conn, "Current Therapy, 1950," 736 pp., \$10. Goepp and Flippin, "Medical State Board Questions & Answers," 8th ed., 663 pp., \$7. Mitchell-Nelson, "Textbook of Pediatrics," 5th ed., 1658 pp., \$12.50. Wells, "Kinesiology, the Mechanical and Anatomic Fundamentals of Human Motion," 478 pp., \$4.75. (Key No. 384)

Charles C. Thomas, Publisher, 301 E. Lawrence Ave., Springfield, Ill. Diethelm, "Treatment in Psychiatry," 2nd ed., 574 pp., \$8.50. Dunton and Licht, editors, "Occupational Therapy, Principles and Practice," 350 pp., \$6.00. (Key No. 385)

Suppliers' News

The Englander Company, Inc., 2447 W. Roosevelt Rd., Chicago 8, announces the establishment of a **Contract Department** under the direction of Marc Hoffman. The new department will handle an exclusive line of sleep products for hospitals and other institutions.

Mealpack, Inc., manufacturer of heat-retaining, individual-meal food trucks, announces change of name to **Mealpack Corp.** and change of address from 152 W. 42nd St., New York 18, to 2014 Ridge Ave., Evanston, Ill.

Puritan Compressed Gas Corp., 2012 Grand Ave., Kansas City, Mo., manufacturer of "Puritan Maid" medical gases, announces the opening of its newly constructed offices and plant at the southwest corner of Clayton and Boyle Avenues, St. Louis, Mo.

Will Ross, Inc., manufacturer and distributor of hospital and sanatorium supplies and equipment, announces removal from 3100 W. Center St., Milwaukee 10, Wis., to its newly completed office building at 4285 N. Port Washington Rd., Milwaukee 12, Wis.

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